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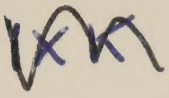

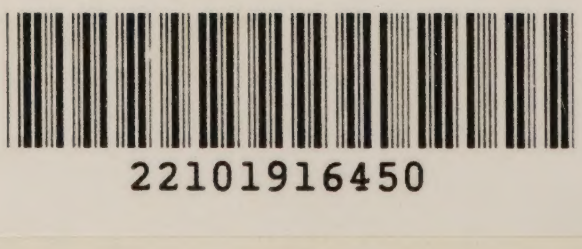

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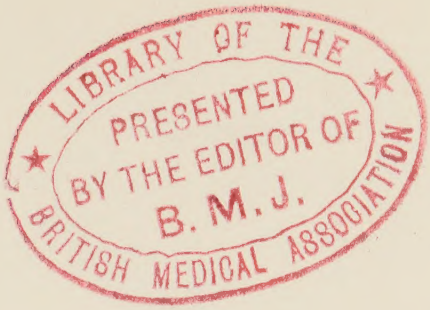
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Emotional Factors in Public Health Nursing

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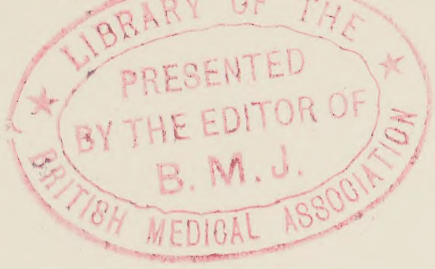

A Casebook

Emotional Factors in Public Health Nursing

PREPARED BY THE WISCONSIN STATE BOARD OF HEALTH

Abraham B. Abramovitz, EDITOR

Madison, 1961

The University of Wisconsin Press

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Foreword

by IONE ROWLEY, R.N.
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During the last ten years nursing education and periodicals have emphasized the need for nurses to understand their own behavior and that of their patients and co-workers in order that they may be more effective as "helping" persons. Paralleling the developments of medicine and public health, the roles of nurses are changing. Because of short-term hospitalization and the more general use of hospitals for other than critical and terminal illness, often skilled bedside care is needed less than is help to patients in accepting and managing the personal implications of the condition requiring the hospitalization. Today, many of our earlier problems in public health have been brought under control through immunization and sanitation as well as through improved medical care. The public health nurse is in a unique position to help individuals and families accept greater responsibility for their own health. She is often the one worker who meets the family before trouble arises. In the normal course of a day's work she meets families at a time when life situations that normally cause varying de-

grees of stress and anxiety are occurring or can be anticipated—birth, school entrance, adolescence, marriage and parenthood, illness and aging. She can assist the family in applying scientific knowledge about health, and about growth and development, and, hopefully, help them to recognize and meet human needs.

Today nursing, along with other fields, is reflecting some of the implications of research and practice in the social sciences. While there seems to be little confusion or doubt about the goals of nursing, medicine, social work, and teaching, discrepancies often occur in the means used to attain them.

Nurses in all fields admit the importance of emotional, social, and economic factors to the patient's welfare. As a result, hospital practices have changed. Recognizing the normal anxiety of approaching parenthood, maternity services now provide orientation tours before delivery, allow husbands in the labor room, and have various kinds of rooming-in plans for the new mother and baby. Pediatric wards have relaxed visiting hours, often allowing the mother unrestricted access to her child.

But with all of these evidences of recognition of human needs, do we not still tend to "divide" the person into the physical and emotional components of health and illness? Are complaints of patients without demonstrable symptoms "acceptable" to us? Are we more intent on getting the patient to take his insulin and to eat his prescribed diet than in learning what the disease means to him and how this may affect his total adjustment in the future, including his attitude toward diet and insulin?

If a large percentage of mothers are under medical care by the fourth month of pregnancy and make regular visits to a physician, is this sufficient to insure that the total needs of mothers are met? Although public health has long been

considered a preventive community program, how much importance in practice do we place on public health nursing visits purely for health education and "primary" prevention? Is the public health nurse able to give intensive service to families at the crisis periods when pressures are on her to find and follow up defects?

Our actions often belie our words. We talk freely of "comprehensive patient care" and "family-centered" service on the one hand, and at the same time we splinter family visits into services labeled "infant," "school," or simply "education." Our health departments divide themselves into disease categories; medical and welfare specialties concern themselves with one part of the body or one period of an individual's life.

While public health nurses no longer approach the home visit armed with neat mental "packages" of authoritative information and advice, the changed function causes anxiety and some frustration. Perhaps the next generation of nurses will embark on their careers with the basic mental health concepts, the knowledge and understanding of human behavior, and the learning process as integral parts of their professional skill. Many are schooled in the belief that knowledge automatically results in learning and that information and advice from expert sources will motivate individuals to act in the desired manner. For them there is a long and somewhat painful path to travel.

If we have learned anything in several years of inservice education with groups of hospital and public health nurses, it is that there is no easy way to acquire this understanding. Certain devices and materials have proved more helpful than others, case material being one in particular. Because some find it difficult to offer personal experiences for fear of exposing their inadequacies, and because others may not have the opportunity, we have found there is often a dearth

of case material available for group study. By gathering the cases herein for our own use and that of others who may have the same need, we hope to make available a resource useful to many. Because people and behavior are the focus, rather than public health nursing techniques, it should provide common elements upon which all professions can come together and all services can be based.

While this book is the result of an advisory-consultant public health nurse study program, all credit goes to the mental health consultants of the Division of Child Guidance, Bureau of Maternal and Child Health, Wisconsin State Board of Health. The leadership, guidance in case selection, and final preparation and editing were through their efforts. To the public health nurses who contributed many more cases from their files than were actually used, we are sincerely grateful. And, lest we forget our administrators who believed in the worth-whileness of our project and supported us in it, we hope that they are justified by the improved service to people resulting from it.

Contents

Emotional Factors in Public Health Nursing

I

Introduction

by LOUIS H. ORZACK [1]
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This casebook portrays the ways in which persons engaged in public health nursing perform their work. To the outsider, the breadth of their contributions to the resolution of personal health problems is impressive. Underlying these achievements is the provision of emotional support to those in need of help. Yet, the almost infinite variety of situations and of professional behaviors is perhaps the most striking characteristic of the descriptions presented here.

Alternative courses of action continually confront the individual public health nurse and require her to make professionally informed choices. The alternatives themselves, and the acceptability of one choice rather than another, seem to be undergoing change. This casebook itself is evidence of that change. For it reflects the current shift in the expectations of the public health profession concerning the right and proper patterns of behavior for public health

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nurses. Thus, new definitions of what are professional behaviors are being worked out.

One mark of a profession is that it sanctions the addition of new procedures and the replacement of older techniques. The history of any profession can be written in terms of innovations in the methods and behaviors that are appropriately a part of the professionals' roles. At the same time, not all innovations ultimately become incorporated into the repertoire of a professional. Some suggested changes are not welcomed with open arms by those already in practice and by those educators charged with supervision of professional training. Whenever a change occurs, there is a period of time when the new behaviors have not fully taken hold, when their usefulness in day-by-day practice is being tested. Some innovations may be rejected, perhaps wisely, perhaps not; some may be barely permitted. Other changes may earn nothing but hostility although later they may attract wide acclaim; still others may be widely adopted, perhaps too hastily in some cases.

The newer behaviors described here have emotional meaning for both clients and practitioners. This meaning affects whether or not the behaviors are accepted and whether or not professional goals are attained. An extensive range of sociological research on innovation in professional, scientific, and technological settings points to the importance of three additional factors.[2] These are (1) the degree to which the change harmonizes with pre-existing, socially patterned expectations concerning the roles of practitioners; (2) the extent to which the proposal fits in with the systems of ideas of practitioners and of their clientele; and, finally,

[2] See, for example, Herbert Menzel, James Coleman, Elihu Katz, "Dimensions of Being 'Modern' in Medical Practice," *Journal of Chronic Diseases,* IX, No. 1 (January, 1959), 20–40; and E. A. Wilkening, "Informal Leaders and Innovators in Farm Practices," *Rural Sociology,* XVII (1952), 272–75.

(3) the means which exist for communication to occur among (*a*) the innovators of practices, (*b*) those who will put them into practice, and (*c*) those who seek out or receive help from the practitioners.

As I go through the individual cases, my attention is caught by several recurrent themes. The first is that profound changes are implied in the traditional role of the public health nurse. The older pattern is described in the Case of Mrs. Smith, Chapter XI, as including "mechanical aspects." Far-reaching extensions of the role of the public health nurse beyond these mechanical aspects are portrayed. In order that these extensions be fully accepted, substantial changes need occur in what the nurses and clients expect of one another.

Second, the changes in role seem to involve many different aspects of what may be called self-other relationships. This is found in virtually all the cases, although noteworthy illustrations are the cases of Lester, Jerry, Ruth, Mr. K., Carl, and Mrs. Smith. In these are contained references to the desirability of understanding emotional needs, of acquiring a sensitive objectivity to one's own attitudes and those of others, of holding to a professional attitude, of appreciating the meanings which other people attach to situations, of placing one's self in the roles of others, and of avoiding the pitfalls of overidentifying with the feelings of others.

Rules for the pursuit of these goals seem in principle to be difficult to formulate, no matter how desirable the goals might be. What training program should be instituted in order to facilitate the process whereby public health nurses, as well as other professionals, can better understand their own motivations and those of others? There is research evidence which shows that some training in self-other relationships may in fact reduce accuracy in the estimation of other people's feelings and that untrained individuals may often do a somewhat more accurate job than those who have been

trained—perhaps poorly from a professional point of view —in these areas.[3] Here then is a task of the first magnitude: to determine the best methods for training professionals to understand themselves and others so as to improve the effectiveness of their services to others.

The third theme is that the goals of professionals and the goals of clients may not necessarily dovetail, either in the short or long run. This is brought out in various cases, including those of Mr. K., Mrs. Smith, Jerry, and Bobby. The patience of Job, it would seem, is required in some of these instances. The nurse or other professionals may well know what is best for their clients, but there may be a considerable gap in mutual understanding and acceptance. In that situation, what actions are professionally appropriate? At present, the status of public health nurses is not buttressed by the same kinds of institutional controls that teachers, lawyers, or physicians have at their command. Persuasion seems to be the nurse's ultimate strategic resource; typically, she depends upon persuasive communication.

This casebook presents a widely varied array of professional situations to the broad audience of those concerned with behavioral aspects of services to people. It represents one major step toward enhanced communication within the health professions.

In this introductory chapter, various major elements of the content of the cases have been outlined. These elements may be kept in mind by the reader as he studies and discusses the cases. The reader may wish to apply what he has learned from his analysis of the specific cases to issues of broad professional significance. The final chapter will help him focus on these broader issues.

[3] See, for example, W. J. Crow, "The Effect of Training upon Accuracy and Variability in Interpersonal Perception," *Journal of Abnormal and Social Psychology,* LV (1957), 355–59.

II

Purposes and Suggestions for Use of the Casebook

HOW THE CASEBOOK DEVELOPED

For a number of years in continuous inservice training sessions with various groups of public health nurses, case situations taken from various fields of practice have been used for discussion-learning purposes. Through these case discussions, the nurses, with the guidance of the mental health consultants who served as discussion leaders, sought to gain greater sensitivity to mental health principles and insights. Gradually the nurses broadened these insights to a basic understanding of the meanings and purpose of behavior and increased their knowledge of how all people grow, learn, develop, and adjust.

The nurses found the case material a most helpful means of deriving general principles from specific situations and at the same time clarifying the specifics through application of the generic concepts. With this increased understanding of human behavior, the nurses seemed able to carry out their professional role with greater confidence, skill, and satisfaction.

There was growing interest in teaching and learning

through the case method. The cases presented and discussed were increasingly recognized as having great potential value since they could serve as a structured aid in teaching very complex subject matter. Ordinarily it is very frustrating because its abstractions are not easily translated into clear and concrete terms.

In order to implement this potential a workshop was arranged. The workshop participants included all advisory nurses of the eight Wisconsin public health districts, the six consultant nurses of the State Board of Health, the assistant director of the Bureau of Public Health Nursing, and three members of the Division of Child Guidance, Bureau of Maternal and Child Health. The director of the Division of Child Guidance served as the workshop leader.

Prior to the workshop the cases that had been gathered and studied in previous years were reviewed and sifted. Then the advisory and consultant nurses asked local nurses to submit additional cases from their current caseloads. The process of this interaction with local nurses was studied at the workshop. Criteria were established for selection of cases for inclusion in the casebook. Through detailed consideration of about twice the number that could be included, final selection was made of the nine cases in the book. The basis for selection is discussed later in this chapter.

When the selection of the cases was completed, the workshop participants were divided into three subsections, with a mental health consultant serving as discussion leader of each group. Three of the nine cases selected were assigned to each of the subsections. The subgroups then studied these cases to explore general concepts and principles of human behavior and development implicit in them. From these concepts a few were selected from each case to be highlighted in a teaching section on basic principles. The subgroups wrote the original versions of the Basic Principles and the Ques-

tions for Discussion for each case. Then they met as a total group to review and refine their work. Further rewriting was the responsibility of the staff of the Division of Child Guidance.

PURPOSE

The ultimate objective in the use of this casebook is to help nurses, as well as persons in other helping professions, to become more aware of the common feelings and needs of all human beings. This increased understanding of behavior can then be translated into the practical terms of specific professional functioning.

The casebook can be used effectively as part of original professional education as well as inservice programs. Since concepts of understanding and helping people are stressed, rather than specific techniques and skills of any given profession, the casebook can also be used by social workers, doctors, clergy, and others in addition to nurses for whom the book was originally prepared. Reading these cases may help workers in other professions to recognize more clearly how some of their concerns and functions may relate to those of the public health nurse.

THE BASIS FOR SELECTION OF CASES

The casebook is composed of nine cases from the field of public health nursing. A careful attempt has been made to preserve the content, wording, and "flavor" as originally presented by the local nurse. Only minor editorial changes were made wherever necessary for the sake of clarity, confidentiality, and ease of reading. The case material used may be only a small part of the nurse's record or may deal with selected interviews or incidents rather than representing all that is known or dealt with in a total given case situation.

Nurses made their own selections of cases which they

presented voluntarily in writing for inservice discussion purposes. Their choices seemed to reflect basically the following: (1) the nurse's own special involvement in a given case and the consequent feeling that this case had particular significance, (2) the nurse's desire for help in understanding a given case, (3) the nurse's need to justify her efforts and mode of functioning in a given case and to seek reassurance and approval, and (4) the nurse's need to clarify her own role relative to a given case.

In determining which cases should be included in the book the following criteria were applied: (1) cases reflecting needs, problems, and experiences common to many persons served by the public health nurse; (2) at least a sampling of cases presenting unusual problems and needs; (3) cases offering a balanced variety of age groups, types of symptoms, sources and modes of casefinding, categories of services and settings, short-term and long-term contacts, urban and rural communities; and (4) cases clearly illustrating behavioral concepts and principles of significance to the service professions.

STRUCTURE OF THE CASEBOOK

The cases have been arranged in a planned sequence (see the Table of Contents). Each case highlights certain important concepts or a basic focus for study. For example, the Case of Bobby deals particularly with interviewing as a process. It will be noted that the basic concepts or focus of each case may not be fully explicit in the case content itself. But in the suggested study method these concepts will become self-evident to the students as they discuss and evolve for themselves the meanings inherent in the case material.

The sequence of cases is intended to make possible an orderly progression of study from the somewhat less complicated to the more complicated case situation, and from

situations involving young children to those concerning adults. Instructors or group leaders may wish to vary the order. They will find that the cases can be studied as separate units, or other sequences can be followed.

The section titled Basic Principles is not meant to give answers in advance of group discussion, but rather it should be used as a guide against which the group may check its own considerations. This section highlights several basic mental health insights and principles helpful in understanding human behavior. It is recognized that several or all of the cases may reflect and illustrate similar concepts. However, in each discussion of principles, emphasis is on one core idea, making it possible for each concept to be more fully explored. This discussion will be helpful in subsequent cases. For example, the principles of interviewing discussed in relation to the Case of Bobby become meaningful primarily because of the preceding discussions of the cases involving Barbara and Jerry—the recognition of attitudes and feelings and the importance of the professional attitude. The Case of Mr. K., Chapter X, highlights problems in democratization of professional service. This has more meaning when it is related to the discussion of natural resistance to help as presented in connection with the Case of Jerry earlier in the book.

Questions for Discussion follow the Basic Principles. The questions are designed to (1) help explore the meanings of behavior in the particular case, (2) relate these meanings to concepts presented in other cases, (3) help broaden awareness of basic human feelings and the nature of interpersonal relationships, and (4) enable movement from specific cases to generic understanding of all people.

Included in each case unit is a list of references. Primarily they are from publications in the nursing field which are generally available to nursing students and practitioners. But

also included are some references from the behavioral sciences: psychology, psychiatry, sociology, and social work. A few references presenting divergent points of view have purposely been included in order to stimulate independent thinking and to reinforce the values of the objective, open mind. To help increase empathic understanding and to clarify and elaborate concepts, appropriate references to audio-visual aids have been added. For the reader who wishes to extend his study of certain aspects of the book, an additional list of references has been added at the back of the book.

Professor Orzack's concluding chapter is intended for readers who may wish to round out their study by relating everything they have been considering in this book to a broad view of the role of a professional person in our particular society.

SUGGESTIONS ON HOW TO USE THE CASEBOOK

Sensitization to people and increased understanding of human behavior constitute a study which can never be completed but may continue with increased depth of perception. For this reason, the casebook lends itself readily to study by nurses and persons in other helping professions at all levels of training and experience. The advanced student can gain as much from the study of the cases as can the beginning student. With each rereading of a case, one may find insights which were not so fully grasped in a previous reading and discussion. Additional experience in working with people makes the study increasingly practical as it is applied in one's own everyday professional situations.

Although the casebook can be read and studied with profit by individuals, it is designed primarily for group learning through discussion. As in all learning situations the teacher-student relationship is of paramount importance. It is the quality of this relationship that influences significantly the

quality and quantity of learning that takes place. It then follows that the role of the instructor or discussion leader is very important. The casebook is focused on concepts of understanding human behavior rather than on specialized techniques. Skill in nursing comes from an integration of good techniques with a valid understanding of people. The casebook is designed to encourage professional workers to be independently creative in thinking about life situations, to raise their own questions, and to find their own answers in light of their own understanding. The instructor or the discussion leader becomes an enabling force in this learning process. It is assumed that one can self-consciously and purposefully learn to do better those things for which one may already have an intuitive feeling.

In some instances a behavioral science consultant from the field of public health may serve as a resource person. This consultant can be a resource to the group leader or instructor in planning the course of study with the casebook. The consultation may be extended throughout the progress of the course and its evaluation. On occasion the consultant can serve as a resource person directly to the study group by attending some selected sessions on request.

As mentioned previously case units can be studied in the suggested order, individually, or in a variety of sequences. This flexibility allows the casebook to be used as a supplement to a more structured course of study. It can also be used on an interdisciplinary basis, for example, where representatives of various professions are learning and studying together.

Workshops and institutes can use this book for study and as a discussion aid. It is best adapted, however, to study with continuity as in regular classes and inservice training groups where there is the same leader and participants throughout the sessions.

The audio-visual and reading references and the questions can be used as aids in discussion to broaden experience, understanding of feelings, and meanings of feelings. The films, with their attendant discussion, may sensitize one quite directly to the feelings and attitudes of other people and of oneself. Through this sensitization one is enabled to arrive at clear generalizations from specific consideration of a given case. In the Case of Barbara, for example, the mother feels quite overwhelmed with the behavior of her kindergarten-aged daughter. In viewing and discussing the film, "Frustrating Fours and Fascinating Fives," it is possible to explore behavior typical of children of that age. One can feel "with and for" the parents when they are confronted with the "frustrating" and the "fascinating" behavior of children. Identification and empathy with the persons in the film increases one's understanding of the relationship between Barbara and her mother and adds to one's knowledge and understanding of parent-child relationships in general. With increased general understanding one will be more sensitive in subsequent situations involving relationships between other parents and their children.

It is hoped that this casebook will contribute to the educational development of persons in the helping professions. If this book is a factor in enabling the professional person to become more confident, skillful, and satisfied in working with people, the objectives of the casebook will have been fulfilled.

III

Basic Human Needs in Terms of Adaptation Processes

by A. B. ABRAMOVITZ
Wisconsin State Board of Health

INTRODUCTORY NOTE

This chapter attempts to outline some very basic concepts that should be considered carefully in studying each of the cases that follow. It is assumed that an understanding of the most common and significant adaptation conflicts of all persons provides the best available key to knowing what they need, and therefore to being able to provide professional services tailored to meet these needs in more than superficial terms.

From a practical and ideal standpoint, it is of ultimate importance that education, health, and welfare services be founded on an understanding of the best available knowledge of the basic needs of all human beings. While few would take issue with this objective, there are many unresolved questions that probably have hindered programs from founding their services on such understanding.

The following have been some of the obstacles: (1) Human needs have been seen too narrowly, from the standpoint of illness, special problems, and abnormality. (2) Human needs have not been seen sufficiently in terms of their continuity in the life-to-death span of individual development. (3) These needs have been viewed in atomistic fashion without sufficient relationship to dynamic processes of reaction, adjustment, and adaptation.

Many behavioral scientists have tried to list specific human needs. It is significant that while certain fundamental needs seem to be repeated from one list to the next, the number and variety of needs each one mentions cover a wide range. It is the view of this book that a complete list of specific needs is probably unlimited, but the dynamic processes of adjustment can be pinned down more definitely, and any and all specific needs can be related meaningfully to each of these categorical adaptation processes.

Perhaps a fourth obstacle should have been noted above, and that is the false view that any specific need and its satisfaction are in simple, direct relationship to each other. For example, if a child is hungry and needs food, the provision of enough appropriate food automatically takes care of the need. Actually, such a specific need per se has relatively little meaning in the life of the individual and thus cannot be satisfied in and of itself. The meanings that are attached to specific needs are derived from the various adaptation struggles of the human being. This also implies that no need can be satisfied definitively at any one time, and the degree of satisfaction will be always in relation to the continuity and variation of experiences of the person. Again using the example of a child's need to eat, the kind of relationships that he has with his mother now, or that he had in the past, will at present and in the future be a factor determining how well his need to eat is satisfied. In extreme situations the

need may be neutralized or even nullified, e.g., poor appetite or self-destructive refusal to eat.

Although it may be assumed that certain needs like those for self-preservation and survival are present in all people, even these needs are not absolute and have no fixed effect on the life of the individual apart from the way in which such needs relate to the processes of adaptation.

The eleven adaptation conflicts described below are certainly not complete and exhaustive but seem to represent some of the most essential in the experience of human beings interacting with their environments. The viewpoint implicit throughout is that so long as a human being is alive he is in an unsettled state, constantly striving to effect at least a relative degree of balance in contending with a variety of mutually opposed strivings and forces.

This chapter has been used in exploratory discussion with various professional and lay persons. The purpose has been to determine how valid these formulations are as seen in the light of the experiences of these people. They have particularly good opportunity to relate these constructs to child development in very practical situations covering a wide range, from everyday or "normal" situations to those that seem very atypical.

1. *Striving to identify oneself with others versus differentiating oneself from others.*—Each human being is engaged from the very beginning in a never ending struggle to maintain a balance between identifying himself with people outside himself and at the same time trying to establish and maintain himself as a uniquely different individual. He tries to find out continuously the answer to the question, "Who and what am I?" in relation to the question, "Who and what are they?" There is—according to some schools of thought—a fundamental guilt involved in differentiating oneself from others, especially from persons in authority.

2. *Striving for ever increasing independence versus continuing to satisfy specific dependency needs.*—From the very beginning of life each human being engages in an inner struggle between his necessary dependency on other people and the constant evolving toward greater independence and autonomy. The problem is not one of attaining independency or being satisfied with dependency, but to maintain a satisfactory balance between the two, appropriate to one's given life situation at any moment. Obviously, what is a satisfactory balance at one time may not be at another. In other words, there is a constant, lifelong realignment of the balance. In terms of this particular viewpoint traumatic experiences are not significant in and of themselves but only as they may seriously jeopardize the balancing process.

3. *Seeking fulfillment of individual needs and desires versus submitting to outside demands and limitations.*—Each human being through his own internal and external perception has a variety of needs and desires. These felt needs and desires engage in a lifelong conflict for balance with the realistic limits and demands of the total environment. In young infants this balance is maintained only if the people who are caring for the infant modify reality sufficiently. There are some people who never mature beyond this level and go through life expecting somebody or something to keep modifying reality sufficiently so that all felt needs and desires can be satisfied without restraint or limitation. Obviously in the course of maturation this struggle, for those who succeed, involves selectivity, compromise, capacity to endure frustration, etc.

4. *Seeking fulfillment of individual needs and desires versus accepting cultural, moral, and religious values and principles.*—Every individual is brought into a world that has historically established and culturally maintained values and principles. It is a lifelong conflict for all human beings to

maintain a satisfactory balance between their felt needs and desires and the environmentally determined values and principles. Ideally the best solutions come not just in the individual's adapting to the external values and principles but also in his contributing toward modification of these values and principles in a constructive and appropriate manner. In a world like the present one, where values and principles have been considerably jeopardized by many factors, this particular adaptive struggle becomes one of the hardest and at the same time one of the most significant for everyone.

5. *The struggle of the human feeling of not being big enough, wise enough, or powerful enough versus the feeling that the world seems to get more complicated, more difficult to understand, and more technical even in the knowledge that must be acquired for everyday living.*—From earliest childhood human beings, overwhelmed by the overpowering world to which they must adjust, have a natural tendency to compensate by strivings toward omnipotence and omniscience, sometimes real and sometimes in fantasy. As scientific attainment goes forward and gets more intricate in relation to significant aspects of everyone's adjustment, one sees fascinating evidence of immature solutions widespread in the population.[1] For example, in relation to fluoridation of water supplies,[2] in lieu of understanding and accepting the objective facts, surprising numbers of otherwise intelligent people bring to bear the defenses of false omniscience or strange patterns of false omnipotence against the big powers that are hard to understand or control.[3] The same phenomenon may account for the fact that people of good intelligence,

[1] Dana L. Farnsworth, "Emotional Obstacles to Health Programs," *The Journal of School Health,* XXX, No. 2 (February, 1960), especially 51–53.

[2] *Ibid.*

[3] M. Kass, "Fluoridation: The Bigots Jump In," *The ADL Bulletin,* January, 1960, pp. 6–7.

who could understand valid medical interpretation, get involved in spending money, time, and much effort to master pseudomedical rubbish instead.[4] Other interesting phenomena in relation to this particular adaptation process include the following: (*a*) depending on chance, whether through gambling or through give-away programs, to attain the sudden opportunity for power that otherwise is realistically not available; [5] (*b*) the almost fetish-like reverence for encyclopedic knowledge such as helps in quiz programs.

6. *The struggle between experiences in fantasy and experiences in reality.*—The human being is remarkably equipped to respond to reality in such manner that he can make of it almost anything that is or is not there. One may suppose that this is Nature's means of making possible the highest form of human creativity as in art and music. The lines between reality and fantasy are often blurred, and a balance in favor of perceiving reality is difficult to maintain. This particular adaptation process is of key importance in differentiating mental health from mental illness. In young children the blurring of the lines is more marked than it usually is in older persons. Many adults in our culture regard fantasy as something undesirable, something bad, and may so instruct children even to the point of punishing them, viz., they may call the child's fantasy "lying." To recognize the functions of fantasy and to insure its constructive use is perhaps one of the important goals for adults in educating children whether at home or in school.

7. *The struggle between seeking self-satisfaction and less self-centered concern for others.*—This is a lifelong development in all human beings starting with almost complete self-centeredness in infancy. Some very mature people ultimately

[4] Farnsworth, "Emotional Obstacles."

[5] Dan Wakefield, "Harlem's Magic Numbers," *The Reporter,* CCXXXIII, No. 3 (February 4, 1960), 25, 26.

reach the point where the balance is almost fully in the opposite direction, that is, in unselfish concern for other people. As in the other adaptation processes, the real issue is maintaining an appropriate balance under varying circumstances. In actuality there is no such thing as a "selfish" or "unselfish" person. In order to be able to be concerned adequately about other people one must first experience sufficient satisfaction of one's own needs. Those who are labeled "selfish" are really unable to move from themselves to others because they have not had appropriate satisfaction of their own needs. Some take exception to this point of view by pointing out that some people are spoiled by being given too much satisfaction of their selfish needs. On closer inspection, one finds that this is not an appropriate type of satisfaction of the individual's needs but really more a satisfaction to the person who is doing the spoiling. Thus, for example, in the common instance of overprotective mothers, there is little question that it is the mother's needs that are being satisfied and to a much lesser extent the needs of the child. In this basic struggle of self-satisfaction versus unselfish behavior can be included the love-hate continuum which has been of such central importance in psychiatric and psychologic theory and practice. From the point of view presented here, there is no such thing as a dichotomy of love and hate, but rather both are functions of the way in which one relates self-satisfactions to providing, or hindering, satisfaction of the needs of other people.

8. *Complex perceptual experiences versus the striving for simplified organization and consistency.*—Even before birth every human being is bombarded by an untold number of experiential stimuli. It would be completely impossible either to react appropriately at the moment, or to have a progressive development, unless these varied never ending stimuli were subjected to some organizational process which not only ties

these experiences together but also gives a backbone of consistency to them. This struggle to maintain a balance in favor of organization and consistency is lifelong and at various times for various individuals may be very precariously maintained, if at all. From this point of view, one might regard some of the aberrations of the mentally ill patient as gross failure to maintain organization and appropriate consistency. Peculiarly enough, some people are "too good" at maintaining organization and consistency, and this sometimes results in such difficulties as seen in certain rigidities of neurosis. One wonders how helpful parents and teachers are in assisting children to acquire skills of flexible and appropriate organization toward consistency. Many adults these days, with the increased bombardment through movies, television, speed, etc., have become dangerously inconsistent and disorganized. One sees the phenomenon of overcompensated organization and consistency of a distorted or displaced type, for example, the reading of reviews of digests instead of original material, rigid scheduling of leisure activities,[6] blanket reverence for gadgets.

9. *The struggle of anxiety-producing factors versus the freedom to act, think, and feel without excessive inhibition or distortion.*—It is quite generally agreed in psychiatric and psychological theory and practice that nearly all forms of human maladjustment, no matter what the specific symptoms, are expressions of excessive anxiety. Anxiety, however, is not something of an all-or-none nature. It is something we all have constantly and necessarily in some form or some measure. The struggle here is in maintaining a balance in favor of mild anxiety which serves a protective function in

[6] F. R. Dulles, "From Frontier to Suburbia," in *The Nation's Children,* I: *The Family and Social Change,* ed. E. Ginsburg (New York: Columbia University Press, 1960), especially pp. 15–16.

all everyday adjustments. Anxiety can get out-of-bounds and distort the way we think, the way we act, and the way we feel. Normally, anxiety tends to be an automatic function, but it seems desirable and possible to teach human beings from the time they are very young to have insight into, and self-conscious awareness of, the anxiety mechanism. From the point of view presented here, a child well instructed in this manner from earliest childhood will be much less likely to fall into the trap of "blind anxiety," that is, the kind that will operate on a so-called unconscious level, the type that does incalculable damage to people.

10. *The struggle of rote experiencing versus communicating experiential meanings to oneself and others.*—The human being is remarkable in the animal world in having a dual-response system. On the one hand he is able, like other animals, to react and to respond very directly and quite automatically. Unlike other animals, however, he is also able to mediate his experiences through a remarkably intricate communication system. That is, the individual's experiences can be given meanings which he self-consciously attains and which he can communicate to others. The levels of such communication cover a tremendous range, with writers, creative artists, philosophers, etc., at the highest end of the scale. Even very young children can be taught self-consciously to attain deliberate and refined skills in communicating such meanings of experience to themselves and to others. The work of Ojemann in relation to pupils in school is based almost entirely on deliberately teaching children such two-way communication of the meaning of experience. There are those like the outstanding psychiatrist Kubie who think that all important adult-life adjustments can be improved—including the capacity to maintain a good marriage—by lifelong deliberate instruction in this communication of mean-

ings to self and others. Interviewing, as an art and science which has been developed so much in the past few decades, represents deliberate techniques for the same purpose.

11. *Experiencing essential ongoing change versus resistance to change and the need to consolidate experience.*—A basic fact of human life is never ceasing modification and change. This includes even the biological shedding of one's cells and constantly replacing them with new ones. Change has to be established and has to be tolerable to the person and thus there are frequent normal resistances to the process of change. Sometimes the resistance is fleeting, or it may be long-lasting fixation or something in between like the so-called plateaus in learning. At the negative extreme are the throwbacks or the regressions. Under this particular adaptation struggle is included the whole area of the various human maturations and the patterns that have been spelled out increasingly well during the past three decades through the work of such people as Gesell. In a world that moves and requires movement at a very accelerated pace, like our own particular civilization, there is probably no other adaptation conflict more important than this one of continuous adjustment to change.[7] It is assumed here that constructive adaptation to change can be taught, beginning with children at a very early age and even applied to adults at a very advanced age.

[7] Farnsworth, "Emotional Obstacles."

IV

Mainsprings of Behavior

CASE OF BARBARA

The public health nurse first became acquainted with the family of Barbara prior to her birth. Contacts were maintained from 1946 well into 1957. The case is presented in the form of summaries in chronological order from September, 1946, to June, 1957. Almost verbatim accounts are given of two interviews occurring during the home visits. There is a span of approximately six years between these interviews. At the time when service was first initiated the family seemed to be economically in fairly comfortable circumstances. The father was a laborer with adequate income, and the family had their own home which was comfortable and kept in neat order.

September, 1946.—The nurse made the first antepartum visit, on referral by a family friend, for health instruction. The mother seemed very nervous. She nauseated early in pregnancy and said she did not wish to breast feed.

February to September, 1947.—An infant girl was delivered February 11, 1947. The nurse continued the home visits, giving instructions and demonstrations in care of the infant. When the infant was two months old, the mother was

extremely upset because her husband did not wish to have the baby baptized. This was, however, accomplished later when the matter was discussed with their minister. During this home visit the mother informed the nurse that she disliked her own parents, that her father had beaten her, and that her grandparents had practically raised her. The mother was continually fretting to the nurse that she was afraid her child would not walk and talk at an average age.

September, 1947.—Barbara was seven months old. At this time the mother informed the nurse of a new pregnancy. The mother seemed very disturbed as she felt that this was too soon. It was about this time that Barbara began sleeping poorly. She slept in the same room with her parents.

December, 1947.—In December, when the nurse called, the mother informed her of her miscarriage and said her doctor had advised against further pregnancies because of her nervousness. Barbara was more and more wakeful at night, receiving several bottles of milk during the night and as a result eating poorly during the day.

June, 1948.—Barbara, sixteen months old, was hospitalized because of pneumonia. When she returned home she would not sleep in her own crib and was fearful of the dark. She was still drinking several bottles of milk during the night. It wasn't long after this that toilet training was started; the mother used much pressure, scolding and shaming when the child was not successful. It distressed the mother very much when Barbara would urinate on the floor and then show it to her.

August, 1949.—Barbara was displaying frequent temper tantrums and was still drinking from the bottle. She played out-of-doors, but had no playmates.

The nurse made several visits during the next year, and not finding anyone home assumed that the mother was working.

March, 1951.—The nurse met the mother on the street and she asked the nurse to visit her again. She stated she was trying to become pregnant. While the mother had worked for a few months, a neighbor had taken the bottle away from Barbara.

May, 1951.—Home visit. The mother said Barbara was eating much better, was able to be out-of-doors and play with other children, and was sleeping well at night. The mother offered the information that the only difficulty she ever had in raising Barbara was weaning from the bottle. She talked considerably about wishing to become pregnant.

October, 1951.—The nurse hardly got into the house before the mother was talking about becoming pregnant. She stated that so many people have children when they do not want them that she could not understand why she did not become pregnant when she wanted a baby so much. When the nurse talked about dental care for Barbara, the mother stated that Barbara liked to brush her teeth, but used large quantities of toothpaste because she liked to squeeze the tube and smear the paste. Barbara was very anxious to go to school and would enter kindergarten the next fall.

There were many more visits made than are recorded here. The nurse tried to keep the mother informed as to the development of the child and what could be more or less expected of children at different ages. Sometimes it seemed a hopeless proposition, as for example, the pressure the mother had placed on Barbara in toilet training even though the nurse had discussed the importance of a child's readiness for training before it could be successful. The mother accepted the nurse well and talked freely; no doubt she felt that the nurse was one person she could let off steam to. The nurse realized that the mother was emotionally upset and was very careful not to be critical or push any suggestions the mother did not wish to accept. At the time of the nurse's last visit, the mother seemed calmer and more settled; she held Barbara in her lap where she fell asleep and

she seemed to show more affection for the youngster than she had previously.

Interview during Home Visit.—Mrs. M., who had just arrived home from shopping, greeted the nurse with friendliness; and while she was putting the groceries away, the nurse spoke to Barbara:

NURSE. Hello, Barbara. Do you help your mother carry the boxes and bags home? [Barbara nodded yes]. It's a long way to the store. Do you walk all the way? [Barbara nodded yes again.]

MOTHER. Sometimes she rides her tricycle, but we make better time when we walk.

BARBARA TO MOTHER. I want a cookie.

MOTHER. No, you cannot have a cookie. [Barbara climbed on her mother's lap, and it wasn't long before she was sound asleep.]

MOTHER. I'm still trying to become pregnant; I cannot understand why I don't. There are so many people who have babies and they do not want them.

NURSE. Did you know, Mrs. M., that there is only a short period during the month, about two days, when it is possible for a woman to become pregnant?

MOTHER. The neighbor women keep kidding and asking if I am pregnant. It's a regular joke as they all know that I want to have a baby. I am going to take care of my one-and-one-half-year-old nephew when his mother goes to the hospital to have her baby.

NURSE. That will be nice. Is Barbara happy about it?

MOTHER. Oh, yes!

NURSE. Because of the difference in their ages, they will not have much in common, and it would be natural if Barbara is jealous of the attention you will of necessity give your nephew.

MOTHER. Oh, I don't think she will be jealous as she loves babies.

NURSE. Barbara can help you care for him, and if she sees that you love her just as much even though your nephew is here, she will enjoy him too. Does Barbara have any playmates?

MOTHER. Yes, but they are all in school in the afternoon. You should see Barbara climb, she is a regular monkey. Barbara wants to attend school but she will not be five until February, so we thought it best to keep her home another year. When they took the school census this summer, the girl left a medical and dental examination blank.

NURSE. Has Barbara ever visited your family dentist?

MOTHER. Yes, she has, and the dentist says she has very good teeth. Barbara likes to brush her teeth, but she uses so much toothpaste. She likes to squeeze the tube and smears the paste. Her father also uses so much paste.

NURSE. One can make a home tooth cleanser with three parts of baking soda to one part salt. This is very satisfactory for adults but it is not advisable for smaller children as a child could breathe the powder into the lungs. I see that Barbara has a nice desk and chair. I suppose she likes to color and play with clay.

MOTHER. I stopped buying crayons because she ate them. She might like to use clay; I hadn't thought of that. Every time we pass the school Barbara stands and watches the children playing in the school yard. The teacher has invited us to visit, but I am afraid Barbara would be a nuisance.

NURSE. I expect that Barbara would like to see the inside of the school where her playmates are. The teacher would not invite you if she thought Barbara would be a nuisance. Actually the teachers like to have youngsters visit the spring before entering kindergarten.

The mother arose to carry Barbara to her bed, and the nurse also rose. The mother went to the door with the nurse and remarked that she had noticed her pass the house several times that summer and figured she was calling on a new baby down the street.

February, 1952.—Mrs. M. informed the nurse of her pregnancy and stated that she had been feeling miserable (nausea, vomiting, and extreme backache).

July, 1952.—An infant girl named Lucy was born July, 1952, breech delivery. The infant was not in good condition, according to the mother—she had received oxygen and a blood transfusion.

September, 1952.—Barbara started school. The nurse had informed the teacher about the home situation. Later, the teacher said Barbara had made an excellent adjustment to school and got along well with other children. She would come early at noon to visit with the teacher, mostly about her baby sister. The doctor recommended that Barbara have a T & A as she had been having considerable throat trouble.

Infant Lucy was developing normally. Mrs. M. stated that she was not as nervous taking care of this baby and mentioned frequently that the baby was much better than Barbara had been.

February, 1953.—The father was at home when the nurse called, and he started showing Lucy to the nurse and remarked how much healthier she was than Barbara. He said he wanted another doctor's opinion regarding a tonsillectomy for Barbara. After the father left Mrs. M. stated that he did not assume any responsibility in caring for the children and that he did not wish to stay with them while she went out. She said, "Lucy will not leave me out of her sight. When I put on my hat she starts to scream, so I stay home." Mr. and Mrs. M. apparently did not have any social life together. Mr. M. liked to hunt and fish.

The mother said, "If Barbara is to have a tonsillectomy, I do not think my husband or I could explain it to her." The nurse suggested that the teacher could prepare Barbara for this experience if plans were completed for a T & A. (A T & A was done in April, and the teacher did prepare Barbara for this.)

On one of the nurse's visits Mrs. M. mentioned that a neighbor had questioned why the nurse was calling on her. Mrs. M. said, "I told her that the nurse is my friend and I like to have her come and visit with her." The nurse felt that Mrs. M. did gain from these so-called visiting calls. Many of them seemed to be no more than that, if measured by the amount of health information given. The nurse decided to space her visits farther apart, enough to keep in touch but not enough to make it obvious to any neighbor or to cause any resentment on the part of Mrs. M. It was important that she continue to think of the nurse as a friend.

August, 1953.—Mrs. M. stated that Mr. M. had a lump removed from his head. She mentioned that Barbara was eating much better and sleeping much more quietly since the T & A. Barbara was anxious for school to start.

February, 1954.—Mrs. M. was expecting a baby in April. She stated she had been feeling terrible and went from one complaint to another. She said she wanted a girl as she could not hope for a boy. She was distressed because Lucy was not toilet trained, whereas Barbara had been completely trained at this age.

April, 1954.—Robert was delivered normally.

August, 1954.—Mrs. M. was having her teeth extracted. The infant boy was developing normally, apparently eating well and sleeping soundly at night.

January, 1955.—Mrs. M. had her dentures, but stated she was too nervous to wear them at night or to eat with

them in. At each visit Mrs. M. fretted a great deal about how nervous she was and how much work there was to do. She stated that she did not wish to have any more children. She did not seem to have much of a social life either with her husband or alone.

June, 1956.—Miscarriage.

April, 1957.—Miscarriage.

May 2, 1957.—When the nurse called, the mother was extremely disturbed. She stated that her husband had been drinking, that he left for work in the morning and did not return until the early hours of the next morning. She said she could not go on this way, that she could not stand him, and had refused him his marital rights. He had told her to leave him because he would not leave. Mrs. M. said, "Why should I leave him and be saddled with three children and let him go scot-free?" The oldest girl, Barbara, cried a great deal and kept asking her mother not to leave her. Lucy, the five-year-old, wet the bed at night, and the three-year-old boy was not toilet trained.

May 27, 1957.—Mrs. M. seemed unusually calm and relaxed at the time of the nurse's visit. She stated that recently she had spent four days in the hospital because of an ingrown toenail; she was found to have diabetes. Her husband had taken care of the children while she was gone, and after she returned home they had a long talk about their family situation, and both decided to make a greater effort to get along. She said it was a great shock to learn that she had diabetes, and the hardest part would be the restrictions on sweets. She said she was not satisfied after eating a meal if she could not have dessert and that she ate up to four candy bars at a sitting. When the children awakened from their naps, she greeted them affectionately, and they started playing with their toys. The husband called asking about some groceries he was to bring home. Mrs. M. looked pleased that he called

but said smilingly, "It has taken him three days to remember to bring potatoes home. He was so helpless when I was in the hospital, he had to keep Barbara out of school one day because he could not dress Robert. I can put up with anything but the drinking."

When the nurse left, Mrs. M. asked her to come again. She said, "You know, my folks do not come to see me, and it is good to be able to visit with you."

June 18, 1957.—Home visit. Mrs. M. was mowing the lawn when the nurse drove up.

NURSE. Hello. This is a nice afternoon to be out-of-doors.

MOTHER. Hello. Let's go into the house.

NURSE. I don't want to interrupt your work.

MOTHER. It is time for me to rest anyway. [Both entered the house.] This house is a mess; but I have been trying to bake and work outside. And the kids run in and out, always wanting something different to play with.

NURSE. Taking care of a family certainly requires a lot of work.

MOTHER. I don't think my husband appreciates me. I papered this room and when he came home he said, "What are you doing up on the ladder? You had no business climbing with that foot of yours." I said, "I just saved you a week's grocery bill by doing this myself."

NURSE. The paper is very pretty and you certainly did an excellent job.

MOTHER. My husband will be through over at the plant the end of this month. The whole plant will shut down.

NURSE. I am sorry to hear that. There will be many families in this area affected.

MOTHER. I am going to work as my husband will not be able to find another job. I was a looper at a hosiery plant, and I can go back anytime I want to.

NURSE. It would be a change for you to get away from

the regular housework routine. Would you like working again?

MOTHER. No, because then I would have to be washing, cleaning, and baking until late at night. I get so mad at Barbara because she does not want to take care of Robert and Lucy. She wants to be with her friends all the time. They are telephoning to each other all day long. I was never able to do that when I was her age. I was shoved from one relative to another so that I hardly knew where my home was.

NURSE. I noticed a number of children playing in the yard. It is nice that you allow the gang to play in your yard. Barbara is just enough older than Lucy and Robert that they would not have the same interests.

MOTHER. They always play here, but I like that. I know where they are. I don't know what I am going to do with Robert. I put training pants on him the other day, and he cried and cried until I put his diapers back on him. I never had any trouble with the two girls.

NURSE. Sometimes children are not ready to give up their baby ways as soon as we think they should.

MOTHER. I remember when Robert was a baby that Lucy wanted to be put back in diapers. He will not sit on his potty chair, and the doctor said I should not spank him. He will stay dry all night, but Lucy wets the bed at night so I have all that extra washing. [Just then Barbara could be seen coming toward the front door.] I can't stand that Barbara today.

[Barbara brought a kitten into the house and her mother said, "Come here and let me tie your hair back. It is too hot to let it hang on your neck." Barbara dumped the kitten into her mother's lap, grinned at the nurse, and swished out of the room.]

MOTHER. I don't know what I will do next year when she goes to the Central School. I will worry all the while she is

gone. She will be eating her lunch there. She eats so funny. She will not eat potatoes, and she tells Lucy not to eat them either or she will get fat like her mother. She eats a lot of meat, fish, and eggs.

NURSE. Those are all good, nourishing foods. You appear to have lost some weight. I suppose it is hard to stick to your diet, especially when you bake cakes and cookies for the family.

MOTHER. Oh, I can do it. I can leave it alone as I know I have to, but I am not satisfied. I feel hungry all the time. [She stroked the kitten affectionately.] His name is Tiger and I had to feed him with an eyedropper when he was small. My husband says I would make a good farmer as I love all animals. I was never allowed to have a kitten when I was a child. My father had a Persian kitten one time, but my mother made such a fuss that he had to get rid of it.

NURSE. Children usually like to have pets, and it is fine that you enjoy them also because they are extra work.

MOTHER. I am going to visit relatives for a couple of days soon. They are coming to pick me up.

[The telephone rang so the nurse arose as the mother went to answer it. She told the party she would call back. The mother followed the nurse to the door.]

NURSE. It will be a change for you to get away for a few days, and I am glad that you are planning this visit.

MOTHER. Be sure and come to see me again.

NURSE. Yes, I will.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF BARBARA

Factors in Changing Behavior.—There is much concern in the present-day world with getting people to behave differently than they would do on their own in various circumstances. Various professional persons, commercial agents,

politicians, and others are constantly seeking to change people's behavior. It is usually assumed that these modifications would be good for the people involved. There is not enough concern for what the people themselves consider good or whether they actually want to do what is good for them. In light of this, it is not surprising that the chief emphasis is on giving people facts and information and subjecting them to some kind of persuasion. This emphasis on facts and persuasion is not by any means new in human affairs. In fact, it is very deep rooted. Science and pseudoscience have reinforced this pattern.

The more recent developments in the behavioral sciences have emerged with a strong challenge to this entrenched point of view. The challenge comes from the behavioral-science principle that the main sources of human behavior are in the feelings, attitudes, and life experiences of the individual. This principle undermines the long-standing emphasis on using reason and facts as the basis for voluntarily and purposively changing behavior in oneself or in others. An important corollary to this principle is that to change one's own behavior, or to help other people change theirs, requires understanding and recognition of the feelings and attitudes of the person and his relationships with other people.

These considerations are basic to the techniques involved in interviewing, which is the main professional channel for helping others to gain increased self-understanding and thus to be able to modify behavior in a healthy way.

Recognition of Attitudes and Feelings.—An effective way to recognize the significant attitudes and feelings of another person is to try to see the situation from his viewpoint. This means not merely listening to his words but also being aware of the meanings behind the words and being sensitive to the nonverbal reactions as well. Barbara's mother sometimes

tells us more about herself and her relationships with her family through her nonverbal behavior than through the words she uses.

A nurse can greatly enhance her contribution to the patient through a sensitive and objective attitude. This means that the nurse is aware of and understands her own attitudes and feelings. She is able to make a distinction between her needs and feelings and those of the other person. It also implies that the nurse has sympathetic tolerance for herself and others as fallible human beings. In essence, this is what is usually meant by such terms as "being nonjudgmental," "accepting the patient as he is," and "being objective."

Complexity of Reaction and Interaction.—This case rather clearly opens up some basic issues regarding the meanings of interpersonal relationships in any group, such as family. For example, how does the experience of one member affect all the rest? Are the factual events important apart from the reactions of individuals to them? How do the reactions of each person interchange with those of the others in the group?

People's feelings are neither simple nor clear cut. There are things which we want and do not want simultaneously. We often have mixed feelings about significant happenings in our lives; this is true even of things we want or regard as desirable. Our total life experiences contribute to these mixed feelings. Experiences in adulthood may reactivate and intensify feelings stemming from our childhood. This will be more likely to occur under trying circumstances in adulthood.

Relationship between Patients' Needs and Nursing Service.—The primary objective of any nursing service is to help the patient help himself. This involves helping him to feel he is capable of taking responsibility for himself. In working professionally with any person, we become concerned with

his basic needs. (Chapter III discusses basic needs in terms of adaptation processes.) Prominent among these needs is the continuous need to struggle for a balance between necessary dependence and strivings for independence. It is important for the nurse to recognize that the way the patient works out this balance in the present situation will somehow be influenced by the ways he used in the past. Past and present will affect his future adjustment. In other words, the function of the nurse centers on helping to strengthen the patient's long-range capacity for adjustment. The helping process will require skill in relating the present situation to both past and future.

In giving service it is natural to seek immediate results and to try to resolve problems directly. Thus, we may concentrate on symptoms rather than causes. Service which focuses on strengthening the whole person and which gets at meanings and underlying causes rather than surface symptoms is bound to be a slow process. Although slow, this type of daily practice in public health generally proves to be more efficient in the long run.

SOME QUESTIONS FOR DISCUSSION

1 When a professional person seeks a change in the behavior of a client, what principles should he take into account?
2 How do we determine who is actually the patient or the focus of appropriate concern in any referral?
3 What do you think are some of the effects of the mother's own childhood experiences on her present behavior?
4 What similarities do you see in the development of each of Mrs. M.'s children?
5 How does the nurse see Mrs. M.'s needs? How does the nurse react to Mrs. M.'s feelings about herself?
6 Note the timing of the nurse's home visits over a period

of many years. Discuss what might be the nurse's rationale for this pattern of timing. What principles and determinants should generally guide a nurse in timing her visits?

7 How do the mother's feelings interfere with her ability to help her children? What nonverbal clues are there to her feelings?

8 What is the nurse's responsibility in bringing about a change in her own behavior? In the mother's behavior?

9 How do we help other related agencies understand the mother's behavior? How can we protect the confidential nature of the nurse-patient relationship?

10 Compare interviewing techniques in the two recorded interviews.

11 What does it mean to a child to be separated from his parents? What does it mean to the parents?

12 How does the relation of the nurse to the mother influence the latter's relations with others?

13 What clues are there in this case to the nurse's attitudes, feelings, and needs?

REFERENCES

1 The American Public Health Association, Inc. *Health Supervision of Young Children.* New York, 1955, pp. 13–43.

2 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 3–26.

3 Caplan, Gerald. "The Mental Hygiene Role of the Nurse in Maternal and Child Care," *Nursing Outlook,* II (January, 1954), 14–19.

4 Garrett, Annette. *Interviewing: Its Principles and Methods.* New York: Family Service Association of America, 1958, pp. 7–20.

5 Hartrich, Paulette. "Parents and Nurses Work Together," *Nursing Outlook,* IV (March, 1956), 146–48.
6 Towle, Charlotte. *Common Human Needs.* New York: National Association of Social Workers, 1952, pp. 11–36.
7 Wolff, Ilse. "Interviewing in Public Health Nursing," Parts I and II, *Nursing Outlook,* VI (May, 1958), 267–69; and (June, 1958), 320–22.

DISCUSSION AIDS

Films:

"Working for Better Public Health through Recognition of Feelings," United World Films, Inc., 1445 Park Avenue, New York 29, N.Y. 25 minutes.

A professional worker approaches a client with a fixed plan to change the client's behavior. The worker is surprised, frustrated, and angry when his reasonable plan is rejected. After discussion with his supervisor and a chance to release his own feelings, he realizes he cannot solve the problem at hand until the feelings and resistance are given expression and a relationship of mutual understanding is achieved.

"Broken Appointment," Mental Health Materials Center, New York 19, N.Y. 30 minutes.

A public health nurse discovers emotional factors that have made a miner's wife break three appointments for a prenatal examination. The film emphasizes how understanding a patient's emotions can be as important as interpreting physical symptoms.

"Frustrating Fours and Fascinating Fives," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 22 minutes.

This film is a documentation of typical behavior at ages four and five. It shows Roddy in a modern nursery school,

takes up problems of discipline, and shows what may be expected of and explained to a child at four and five.

"Preface to a Life," United World Films, Inc., 1445 Park Avenue, New York 29, N.Y. 20 minutes.

This film emphasizes the fact that parents' situations are the foundation on which a child's personality is built. It helps parents to understand the dangers involved in not allowing the child to develop according to his own capacities and inclinations but rather trying to fit him into a pattern of their own wishes and dreams. The theme is so presented that parents can readily absorb it in a personally meaningful way.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Mrs. Davis Episode," Educational Aids, Brooklyn, New York.

Part I: A clinic nurse helps a pregnant woman face her problems and accept some appropriate responsibility.

Part II: The same clinic nurse helps the patient see how attitudes about oneself are developed.

Part III: The nurse helps the patient see the interrelationship between attitudes toward others and attitudes toward self.

V

Case Referrals: Meanings and Process

CASE OF LESTER

The X. family consists of the parents in their early forties and five children, four of whom are boys. The youngest child is a girl.

Referral.—The family has been known to this agency since June, 1941, when neighbors reported to the office that three-year-old Lester (then the youngest child) was running around the neighborhood with his body covered with sores.

The nurse called at the home to see this child. She found that Lester was suffering from a very bad case of eczema which he had scratched and it had become badly infected. The child was under medical care for this condition and had been taken to the doctor periodically since early infancy when the condition developed. The doctor had prescribed an ointment to be applied to the whole body. The child was most uncomfortable and cried a great deal, was restless at night and appeared tired. The doctor had also recommended that Lester be taken to the state general hospital for allergy

tests to determine what was causing the eczema. The family could not afford to consult a private dermatologist; hence they were eligible for care at the state general hospital at county expense. The father had full-time employment but was not earning enough to provide a specialist's care. The mother was pregnant at this time which was just a few months before the little girl was born. Mrs. X. was not feeling very well and seemed to have more than she could do to care for her four children, prepare meals for the family, tend her house, and give Lester the extra care he needed. The house appeared untidy, but the children were clean.

The nurse assisted the mother in applying the prescribed ointment to Lester's body and urged her to see her physician more frequently, both for herself and the child. The nurse also urged the mother to take Lester to a dermatologist and explained that there would be no charge to the family. The mother seemed discouraged at this time and gave various reasons why she could not go to the state general hospital, mainly that she thought Lester's condition was improving. This did not appear evident to the nurse.

Late in July several complaints were again received from neighbors who said the child was neglected. Repeated home visits were made, and the nurse felt the mother was trying to give satisfactory care to the child, other than coöperating in the suggestion that she consult a dermatologist. About this time the family was turned over to another nurse. According to her notes in the record, the skin condition would improve temporarily, but it recurred at intervals. In July of 1943, the mother agreed to take Lester to the hospital. The nurse again explained the procedure to follow. A September visit this year showed that nothing had been done but that the skin condition had improved.

In 1943 Lester entered school for the first time, and his kindergarten teachers were quite concerned about his ap-

pearance. The skin trouble was explained to them, and he was accepted at school as not having a contagious disease.

Several years elapsed and no special problems were reported in the home. Then Lester's teacher asked the nurse to see Mrs. X. again because Lester was again most uncomfortable with his skin condition. He also needed an eye examination and probably needed glasses.

To follow up the teacher's request, the nurse called at the home to see Lester's mother. When the purpose of the visit was explained, Mrs. X. appeared interested and anxious to do what she could to help overcome her son's handicaps. The nurse urged her to consult an eye specialist for an examination of Lester's eyes and their family physician regarding the eczema. She was a little apprehensive as to what kind of reception and coöperation she could expect from Mrs. X., as in the past the agency had not accomplished its purpose. However, the nurse was pleasantly surprised after talking with the mother to find that her attitude seemed more receptive than it had ever been before. She even brought up the subject of her lack of coöperation in previous years, stating, "You remember when you wanted me to take Lester to the state general hospital years ago and I didn't do it. At that time I was so involved with care of the children that I just couldn't get away to do it."

Besides Lester's need for medical care, many other family and emotional problems were discussed, most of them brought up by the mother. Because of his handicaps, she was afraid that all his life she had overprotected Lester, both from his older brothers and from outsiders. She said he did not seem to be able to fight his own battles or hold his own as well as the other children. He was not an active child, not interested in sports and other outside activities as his brothers were. He spent a great deal of time reading while the

other children were out playing or working at odd jobs to earn a little money. She blamed Lester's eye trouble on his excessive reading and said that he often read in a poor light in spite of all her scoldings. She also said that Lester was still a little young—he was now eleven years old—to be able to get jobs shoveling snow or delivering papers, whereas his brother, Roland, twelve and one-half, had been doing this for some time. Incidentally, cold weather, of course, irritates the skin trouble and causes it to become worse, whereas in the summertime it is apt to be much improved. Mrs. X. added that even if Lester did want a job, he'd have a hard time getting one, as his brothers were so much more aggressive and anxious to earn money that Lester so far hadn't had a chance.

Lester's teacher, who is a sister in a Catholic school, told the nurse she felt very sorry for the boy because his skin condition often seemed to make him uncomfortable at school. He attended the sixth grade and was an excellent student in spite of his handicaps. His teacher also said he was a very good boy and did not make any trouble at school. He was coöperative, interested in school, and friendly. However, the nurse got the impression from what his mother said that Lester probably did not have as many friends as his brothers and many other children have. The nurse thought this might happen because of his skin trouble. In her experience, she had often found that children do not like other children who are not clean or who have an unattractive appearance. She had found that children can be quite cruel in this respect, thereby perhaps contributing to a psychological problem in the child who is rejected. However, on the whole, she thought Lester is fairly well adjusted in spite of his handicaps.

Mrs. X. also said she wasn't sure that Lester really needed glasses, implying that if he had better reading habits, his

vision might improve. She thought Lester wanted to wear glasses and might have faked his vision defect by refusing to read the eye chart. She mentioned that her oldest son, John, had worn glasses for two years and that he saved the money he earned to buy them. He now needed a change of glasses, and this time she planned to help him pay for them. Lester got along much better with John than with Roland who was nearer his age. The nurse suggested that Lester probably admired John more because he was older.

Mrs. X. also gave some details about the financial status of the family, which had improved a great deal since the first contact in 1941. The information was unsolicited and came out quite naturally. She mentioned that she had just finished papering their kitchen and offered to show it to the nurse. The latter complimented her on its appearance but asked why she did it, since the family was planning to move in a few weeks. The mother explained they had bought the house when they moved there, which was about 1944, and would probably rent it when they left. Her husband was now a district manager of the company for which he worked and was going to set up a new office in the community to which they were moving. As mentioned earlier, this home had formerly been untidy. At this later visit, the condition of the house was improved, but still untidy. Mrs. X. stated that in spite of a fairly good income, they were kept busy providing the necessities for the family, and she mentioned that they were paying dental bills for all the children.

A short time later, Lester's teacher asked the nurse to call again to see the mother. She said the child's skin condition had become so bad that he could hardly walk. On his insteps and under his knees the skin was very raw and painful. The sister said she didn't think Lester's mother gave him proper care and she could not understand why she did not

consult a doctor. The nurse thought the sister was genuinely interested in this child.

The nurse called at the home that day early in the afternoon. Much to her surprise, Mrs. X. was very unfriendly and did not invite her in. "I am busy," Mrs. X. said and looked very cross. The nurse said, "I want to talk with you again about Lester. When can I see you?" She was told to come back at three o'clock, so promptly at three o'clock she returned. She didn't want to be a nuisance but thought the mother would like to know how uncomfortable Lester's teacher thought he was. Mrs. X. berated the teachers and the school and said the parents never belonged to a P.T.A. The nurse told her she thought it meant a lot to the children to have their parents visit school and that they were proud to have them belong to the P.T.A. By this time, Mrs. X.'s expression had changed and she was her old pleasant self again. She talked about many things. She said she would take Lester out of school a few days and treat him herself, but that she would not see the doctor. She thought it wasn't necessary and that he wouldn't have anything new to offer in the way of treatment. The nurse pointed out that there are many new drugs available; and since Lester apparently had a germ infection as well as eczema, the doctor might have something new to suggest.

Mrs. X. observed, "There are many handicapped people in the world today who seem to get along all right. I don't know why people make such a fuss about Lester." The nurse agreed with her, but said these people needed to know that someone cared and wanted to help them. As an example, she mentioned a young boy who was severely handicapped two years before when he lost both his legs in a train accident. The nurse saw him frequently entering the vocational school and thought this boy was living a normal, happy life

because he found that people cared about him while he was convalescing from his illness. On leaving Mrs. X.'s home, the nurse said, "I'll probably not see you again since you are leaving in a few weeks, and I have nothing more to suggest."

A week later Mrs. X. called the nurse on the telephone. She had read in the paper about the orthopedic clinic which was to be held the next week and that volunteers were needed to help at the clinic. She said she had some free time and would like to help. The nurse thanked her and assigned her an afternoon on which she could assist. Again, the nurse was very much surprised at this woman's attitude since she had said she never attended a P.T.A. meeting and was never active in other community projects. The nurse's impression was that Mrs. X. was sorry she had been rather rude to her when she called at her home the previous week. She seemed really interested in worth-while projects and wanted an opportunity to be able to help.

The nurse asked her about Lester. The mother had kept him home from school all week, much of the time in bed so that she could apply some hot boric compresses to the infected areas. She told just how she did it and her methods seemed good. She said she boiled the boric solution and dressings for fifteen minutes so that they would surely be sterile.

She said Lester was much more comfortable and was doing less scratching of the irritated areas. She noted that formerly he had slept with his brother who liked a lot of bedding at night, but now he was sleeping alone with fewer covers and was more comfortable. She seemed quite encouraged about his condition. Apparently she had alleviated the acute skin condition with her method of treatment.

However, the big problem remains in Lester's condition. He still has his allergy which he has had for many years and shows no indication of getting rid of it. If he could have the

care of an allergy specialist, perhaps the cause of his trouble could be discovered and he could be completely cured. Lester is apt to be subjected to disturbing emotional problems as long as the condition persists. Without it, he could be a very normal, happy little boy. It appears that the nurse will not have further opportunity to even try to obtain good medical care for this boy since the family will soon be moving out of town.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF LESTER

Meanings of Referral.—Referrals come to the public health nurse from many sources, for many reasons, and in many ways. The referrals may be made sometimes in a constructive manner and sometimes in a less helpful way. No matter how essential the referral is or how well it is handled, the person referred will still have mixed feelings about his need for service. His conflicting attitudes and feelings will relate to those who helped make the referral as well as to the agency to which referral is made.

No matter what the specific basis may be for any referral, it always implies something is unsatisfactory about the way things are in the life situation of the person who is referred for help. Negative feelings of being criticized, blamed, at fault, chagrined are frequently heightened by the very idea of referral. The client's concept of personal adequacy is challenged. Such feelings may hinder, or even preclude, ability to accept the idea of referral and the help that might be provided.

The Role of Agencies in the Referral Process.—All agencies seeking to understand the people they serve begin with the recognition that referral will automatically have meaning and produce reactions in the client. As professional enabling persons, we help the client by unraveling with him the particular meanings the referral has to him and the nature of

his feelings toward the workers, toward what is offered, and toward the cause of referral. The agency recognizes that the client's attitudes have their source in his feelings about himself, his current life situation, and the continuum of his past experiences. This recognition makes it easier for the agency to accept his feelings, whatever they are, without negative judgment or reprisal for any difficulties his attitudes or behavior may present.

As brought out in the Case of Barbara, the professional worker tries to strengthen the individual's ability to take care of himself and his family rather than to do things for him. Whatever helps him to become more independent as he matures will be fostered. It follows then that each client has the responsibility and the privilege of making his own decisions and his own mistakes. It is not unusual that a worker, with the desire to help, will approach a situation with a preconceived solution. Feelings of disappointment, frustration, and censure will result when the complexities of the patient's behavior do not yield to the preconceived, logical plan, or when the patient refuses, postpones, or disagrees with the worker's recommendations. However important a referral may be, compliance in accepting the referral is much less important than enabling the patient to feel that he has done something which will not detract too much from his sense of personal adequacy.

Timing and Pace.—The timing of a referral is very important and needs to be geared to the pace at which the patient is ready and willing to do something about his life situation. Referral is most effectively suggested when the patient indicates he wants it, rather than when someone else thinks he needs it. Adjusting to the patient's pace means, also, that the referral process is rarely accomplished completely by anyone at the first suggestion. It will more likely be a very gradual process extending over varying periods of time. In some instances it may not be accomplished at all. One re-

sponsibility of the nurse and other professional persons is to recognize the importance of timing and pace in making referrals and to learn how to assess these factors in individual situations. It is vital to detect and understand the patient's indications of discomfort and resistance.

SOME QUESTIONS FOR DISCUSSION

1 Discuss the process of referral in this case. What other procedures in referral can you think of that could be used in this or similar cases?
2 Discuss the meanings of referral as presented in the Basic Principles.
3 What did the nurse's approach mean to the mother? What did the mother's reaction mean to the nurse? Interpret their interaction.
4 What did the referral mean to the mother? What evidence do we have of this from the mother's behavior? How did the nurse respond to the mother's feelings?
5 What did Lester's illness mean to the various persons involved with him? What are the general meanings of illness to patients and to the other persons with whom they interrelate?
6 How can a nurse be most helpful in the school aspects of such cases?
7 Discuss the dynamics of the symptoms presented by the child in this case.
8 Lester was first known to the public health agency at the early age of three. How can very early casefinding be most effectively followed through for preventive purposes?

REFERENCES

1 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 149–60.
2 Garrett, Annette. *Interviewing: Its Principles and Meth-*

ods. New York: Family Service Association of America, 1958, pp. 80–84.

3 Gilbert, Ruth. *The Public Health Nurse and Her Patient,* 2nd ed. Cambridge: Harvard University Press for the Commonwealth Fund, 1951, pp. 12–41.

4 Hubbard, Ruth, Mathilda Scheuer, and Ruth Farrisey. "Referral Plans: 1) Organization of Referral Programs; 2) a Nursing Service Responsibility," *Nursing Outlook,* IV (January, 1956), 18–21.

5 Kaplan, Stanley, and Helen Plogsted. "The Nurse and Psychosomatic Medicine," *Nursing Outlook,* V (April, 1957), 207–9.

6 Owens, Charlotte. "Concepts of Interviewing," *Nursing Outlook,* I (October, 1953), 577–80.

7 Stitt, Pauline. "Who Wants to Know," *Children,* II (November–December, 1955), 213–16.

DISCUSSION AIDS

Films:

"Angry Boy," International Film Bureau, 6 North Michigan Avenue, Chicago 2, Illinois. 33 minutes.

The film presents a case story of a ten-year-old boy whose emotional disturbance is recognized only after he gets into trouble. The child is referred to the local child guidance center where careful exploration by the psychiatric team traces the problem back to its underlying causes and leads to an effective program of treatment. The complex nature of children's behavior and the fact that changes are not wrought overnight are emphasized.

"Face of Youth," Bureau of Audio-Visual Instruction, The University of Wisconsin, Madison, Wisconsin. 28 minutes.

This film stresses preventive work in mental health focused primarily on young children during their most

pliable and flexible stage of emotional growth. Through case illustrations, the film shows that preventive knowledge must be made available to all responsible people in the community so that they may all work together as a team. The effectiveness of a child guidance center in any community depends on understanding all community resources and closely working together with them. The public health nurse, trained to understand preventive mental health principles, can detect problems early and facilitate solution through linking the efforts of home, school, and health agencies.

"Broken Appointment." For a description of this film, see Chapter IV.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Mrs. Barnes Episode," Educational Aids, Brooklyn, New York.

Part I: A clinic nurse feels compelled to carry out the doctor's recommendation for immediate hospitalization of a patient with diabetes.

Part II: A student nurse has difficulty with the patient after she is admitted to the hospital because overdependency was reinforced in the earlier stage of the illness.

Part III: A visiting nurse allows the patient's needs to take precedence over her own nursing goals.

VI

The Professional Attitude

CASE OF JERRY

Jerry is seven years old. His adoptive parents are of moderate means and have their own home with no other children in the family at present. The boy is a second grader in a protestant parochial school. The nurse has observed him in public school, in his present school, and in the home. She has had direct contacts with the child when doing vision screening and audiometer testing. She has consulted with his teachers, school principals, parents, and pastor.

Referral.—The specific problem was called to the nurse's attention by the principal of the public school two years before when Jerry first entered kindergarten. He was unable to adjust socially with other children in school, could not seem to understand simple directions, seemed to bid for overattention by being very naughty, showed either fear or exaggerated boldness, and upset the teacher's program. The principal suggested physical inspection of the throat and a hearing test because of Jerry's speech difficulties. The child's speech was babyish and characterized by stammering which was accentuated when he was upset. The principal had already advised the parents to take their child to the guidance

clinic. The mother was reluctant to accept his suggestion, but the father favored it. When an appointment was made, the mother failed to keep it. The nurse was asked to visit the home specifically to see if the mother could be persuaded to attend the clinic.

Home Visit.—The home was spic and span and in perfect order. (Probably the child was not allowed to touch anything, nor could he possibly enjoy himself here.) Mrs. R. invited the nurse in rather reluctantly, believing she was just another person to complain about the child's behavior. But she soon was willing to unburden herself with his history and her troubles.

Jerry, who had been one in a group of boarding babies, came to Mrs. R. and her husband when he was nine months old; he was put out for adoption when eleven months old, and they decided to keep him. At the age of two, he became legally their child. During this time and until he was ready for school, Mrs. R. continued to have boarding babies, five to seven at a time. She had very little time for Jerry. He was expected to do things which were impossible for a child of his age to do for himself. He had no social contact with other children his age and was made to sit quietly while his mother attended to the needs of the other babies. Consequently, he did things which would gain her attention. For example, if when eating he spilled his food or milk, his mother would feed him and carry him upstairs in order to save wipe-up time. This was some attention at least. As a result, he played he couldn't help himself. The mother was now disturbed because of his lack of ability.

During this period, she had difficulty with her husband. He was quite radical in his views, spent much of his time away from home, drank to excess; and finally she was aware of his association with another woman. Divorce proceedings were begun but after the first court appearance, a reconciliation

was made. Then they bought this new home. Mrs. R. gave up boarding babies because it was time for the boy to enter kindergarten. She decided to give more attention to her home and child. It soon became apparent that the child could not play with other children in the neighborhood, having had no previous association with children of his own age. The children mocked and ridiculed him because of his baby talk. He became very bold and destructive and preferred younger children to whom he could dictate. His destructiveness brought neighbors to his parents, and in this manner he gained much attention from all.

During the course of the interview, the father appeared.

MRS. R. Here is the nurse from school to tell us about our boy's behavior again.

MR. R. Well, I don't know why they can't handle him at school. He does what he is told when he's at home.

NURSE. It isn't that, but the child seems to have such a terrific feeling of insecurity and fear. I wondered if you hadn't thought more of a visit to the guidance clinic, as the principal suggested some time ago, in order to get to the real reason for this sense of insecurity. He does need guidance to help overcome his speech difficulty.

MRS. R. He can speak clearly if he wants to.

MR. R. Well, I told her to keep that appointment.

MRS. R. I still don't see how they can help us. I don't want everybody putting their nose in our business anyway. We have discussed taking him out of school and sending him to the protestant parochial school not too far away.

NURSE. Do you and Mr. R. attend church regularly?

MRS. R. Well, Mr. R. goes. I was really brought up in the Catholic faith, but I am certainly willing for the boy to go with his father. Probably he will become interested in religion. He likes so much to say his prayers. [Yes, the nurse thought, because he had your attention while learning them.]

NURSE. That might be worth a trial, Mrs. R. Suppose you think more about this and discuss it with your pastor.

In due time the child was enrolled in the new school and picked up by bus. None of the neighbors' children went with him. The pastor found it hard to refuse the child admission to school. After the pastor's initial visit to the home, he realized the friction and strained relations there would create quite a problem for the school to overcome.

The new teacher is very capable and understands the situation very well. The following are some of her observations: On her initial visit to the home, she found the mother a very stern person who did nothing but bark orders to the child. The child got to believe that if he wasn't shouted at, it wasn't meant. He doesn't know how to show his emotions properly, doesn't know whether to laugh or cry and changes from one to the other instantly without reason.

The mother states that neighbor children mock and ridicule him. He enjoys himself more with younger children. He is very destructive, has no conception of respect for the property of others. For example, he destroyed a flower bed of a neighbor who is very fussy about flowers, turned on the hose in a neighbor's yard and directed it into an open window to fill the basement with water, picked up another neighbor's key chain and took the keys off, threw them all about and then threw the key chain away.

The nurse's observation is that he does this because the mother assumes neighbors are right and she deals with the child harshly, keeping him home with her for punishment. This the child enjoys because he has his mother's attention.

He can stand an endless amount of pain and suffering. For example, he received a deep cut in the face from a high fall. The cut was filled with dirt, had to be washed out with green soap, and he hardly cried at all. He will say "Good-by"

and "Hello" at odd times to gain attention. While playing a singing game, he had as a partner a little first-grade girl, and he seemed to lavish on her every kindness such as smoothing her hair, etc. Another time, when his father dropped him off at Sunday school, he walked upstairs, turned around and went out again. He was not found until late afternoon with a classmate from his daily school.

Jerry gets spells where nothing can be done with him. These spells start at home and, of course, carry over into the school day. Best results are achieved when he is isolated, for he hates to be left alone and will soon be coöperative. This distaste for being alone dates back to babyhood when the mother was busy with other babies. Often during class sessions he will make believe that he cannot understand. He *does* understand, but wants that needed extra attention. Early in first grade he could be brought out of a discouraged mood by a pat on the back, just as though no kind word had ever been said to him. He now feels more secure and takes praise in a more ordinary manner.

The mother still expects the child to excel in things and to be a credit to her. For example, a week ago she received his report card. He had one *A*, a number of *B*'s and *C*'s and a *C*- in reading, which is still difficult for him because of his speech even though it has been improving. Jerry still pronounces *r* as *w* and *th* as *f*. Immediately the teacher received a note from the mother stating disappointment in Jerry's grades and asking why the teacher didn't send homework for him to do. The mother would be glad to help him. The teacher asked the mother to come to school and discuss it with her, but so far Mrs. R. has not done so.

In early spring, the nurse visited the home with the idea in mind of persuading the family to send the boy to summer camp in an effort to get him away from the family situation. They thought it over, the nurse sent them literature, but they

felt they could not afford it. This probably was not the real reason. The mother did not want the boy to get away from her. The nurse could not convince them that it would be worth while. How can she help get him there? What else can she do? The nurse is sure the mother will never keep an appointment at the guidance clinic.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF JERRY

The Importance of "the Professional Attitude."—Jerry is a seven-year-old child presenting problems in adjusting at home and at school. This case highlights the importance of "the professional attitude." It is a basic component of the helping or enabling process for all professions. This attitude involves many factors, some of which have already been considered in this book and will be elaborated further in regard to this case and others.

Sensitively Objective Attitudes.—It is essential to understand the problem from the patient's point of view and to recognize the importance of the patient's feelings and attitudes and how these affect his behavior. It is equally necessary for the nurse, teacher, social worker, doctor, and all others of the helping professions to strive continuously to recognize and to understand their own feelings and attitudes as much as possible. The professional person, just like the people he serves, is a human being who reacts with feelings to other people, to current situations, and to past experiences. One also needs to understand in universal terms what makes people—patients or professional persons—anxious, angry, withdrawn, or glad.

This means that the professional person has a sensitively objective attitude. He is aware of his own feelings as well as the feelings of the patient and is able to differentiate between them. He can relate these individual feelings to a more

generic knowledge. The professional worker does not seek to ascribe his feelings to the patient, nor does he take over the feelings of the patient as if they were his own. "Over-identifying," or taking over the patient's feelings, results in taking sides with one individual against others in the family or the group. This hinders clear and adequate understanding of the individual in relation to the family as a whole, thereby reducing effectiveness in helping the patient and his family.

Natural Resistance to Help.—Universally, people protect themselves by resisting and fighting against change, new ideas, the recognition of their own inadequacies, or any anxiety-producing situations. (This concept is also discussed in the Case of Bobby.) The professional worker's nonjudgmental, objective, sensitive, and empathic attitude can help the patient gradually to reduce the amount and extent of this resistance so that he can better understand it and deal with it. The need to ask for help, even when one wants help, tends to heighten the natural inclination to resist or fight back in trying to maintain one's autonomy. These feelings may be more intense in situations where the need for help is pointed out by an outside source. The professional person needs to be cognizant of the meaning and extent of the resistance that will be natural in the patient. Help can be given in such manner as to decrease rather than increase his anxiety.

Understanding Causes and Building on Strengths.—Behavior has its roots in multiple causation. Behavior problems have many causative factors of varying degrees, intensities, and levels of subtlety. (See also the Case of Carl.) Since behavior is seldom simple, there is much risk in the expediency of oversimplification. There is also risk of seeking symptomatic relief of difficulties rather than resolution of causes. It is important to recognize and to understand the strengths, as well as the weaknesses, in any given situation. In fact,

the actual and potential strengths in the person and in the situation need to become the focus in the helping process. An inquiring, willing-to-wait, open-minded attitude guards against premature, ill-advised, preconceived, and oversimplified solutions. This attitude enables the professional worker to carry out the function of "helping the patient to help himself" in a dynamic and progressive manner.

SOME QUESTIONS FOR DISCUSSION

1 Discuss what you consider some of the attributes of "the professional attitude." How do these apply to this case? To your own professional experiences?
2 How does anxiety affect interpersonal relationships? How may it affect the professional relationship with patients? Cite examples from this case.
3 What general guideposts can one use in recognizing anxiety in others? In ourselves? To what extent does this nurse recognize the anxiety in the others and in herself?
4 In what ways can one help to reduce a patient's or client's anxiety? Are there any pitfalls in this procedure?
5 What are some of the safeguards a professional worker can use to differentiate his needs from the needs of those with whom he works? What do you think of the suggestions offered in Alfano's "What Rapport Means to Me"? How do these reflect the principles brought out in relation to this case?
6 Discuss the concept of natural resistance to help. Relate this concept to this case. Give examples from your professional experience.
7 What was the goal of the interview in this case? Discuss factors which may change the focus or the emphasis during an interview. Clarify in relation to this case.
8 What questions are raised by this case with reference to foster and adoptive homes?

9 What determines the role assigned to fathers by professional persons working with families?
10 How can a public health nurse proceed in making constructive referrals to child guidance clinics?

REFERENCES

1 Alfano, Genrose J. "What Rapport Means to Me," *Nursing Outlook,* III (June, 1955), 326–27.
2 Burton, Genevieve. *Personal, Impersonal and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 149–69, 197–219.
3 Garrett, Annette. *Interviewing: Its Principles and Methods.* New York: Family Service Association of America, 1958, pp. 21–29.
4 Haun, Paul. "Mental Health for Living," *Nursing Outlook,* V (September, 1957), 512–15.
5 Hearn, Gordon. "A Social-Psychological View of Nursing Service," *Nursing Outlook,* I (November, 1953), 632–33.
6 Smith, Dorothy. "Let's Help Students Learn and Grow," *Nursing Outlook,* V (January, 1957), 16–19.

DISCUSSION AIDS

Films:

"Child in the Middle," Mid-America Films, Lyons, Wisconsin. 18 minutes.

A parent-teacher conference is dramatized in this film, opening up many questions for discussion concerning the respective roles of each in helping a child in school.

"A Long Time to Grow, Part III, Society of Children—Six-, Seven-, and Eight-Year Olds," New York University Film Library, 26 Washington Place, New York 3, N.Y. 27 minutes.

Spontaneous and unrehearsed sequences depict the

struggle of these children in growing toward independence in relation to their parents. In an effort to relieve the resulting anxiety, they develop a strong allegiance to their peer group. Their interest in the world around them continues while they gain in acquiring skills and knowledge.

"Angry Boy." For a description of this film, see Chapter V.

"Face of Youth." For a description of this film, see Chapter V.

VII

Interviewing as a Process

CASE OF BOBBY

The father works in a manufacturing concern; the mother is employed as a secretary. Their son, Bobby, is seven and one-half years old.

Physical examinations.—In 1954, on kindergarten entrance: "L. lateral muscle paralysis—eye." He was operated upon and wears glasses.

In 1957, Grade 2, he was referred to an orthopedist for a foot condition. Now he wears inner wedges on his shoes.

Referral.—Bobby was referred by the second-grade classroom teacher to the public health nurse for classroom observation. (Group tests this year showed average intelligence and better than average achievement in reading.)

Nurse's Report.—"The child is nervous and tense. While apparently deeply interested in his work, Bobby begins shuffling his feet back and forth, sitting on the edge of his chair. This continues faster and faster, then his face flushes and he seems to relax for a few minutes."

Following the observation, the nurse discussed the case with the teacher and gave her literature pertaining to masturbation. She also arranged for an appointment to see the child's mother.

Teacher's Report to the Public Health Nurse.— "Bobby is a very conscientious student. His work in the second grade has been above average in all areas of study. Bobby tends to be a perfectionist, stressing neatness and accuracy regardless of time involved completing his work.

"Socially, he is a well-adjusted child. He is kind and considerate to his fellow classmates and has, therefore, gained much respect and love from them. Bobby is a quiet, well-mannered child. He is not aggressive.

"Bobby' s difficulty began approximately February 3, 1957. While working at his desk he would move back and forth, sliding his chair, almost in a violent manner. His face would become very flushed and his entire body would shake. This movement would continue for approximately one-half to two minutes, cease, and begin again. Only when working individually at his desk is this action predominant. During the times from one o'clock to one-thirty and ten o'clock to ten-thirty this movement would occur six to eight times.

"A definite effect has been shown in Bobby's work. Papers that were previously neat and complete are now a mass of error marks and often incomplete.

"Help is being given in school through the encouragement of activity (watering plants, getting books, etc.) when this movement begins. His mind is taken off his desire to satisfy a need at his desk and after being up and out of a sitting position there is not a recurrence for fifteen minutes."

Public Health Nurse's Visit to the Home.—The mother met the nurse at the door as if anxiously waiting for her to arrive. The mother was well groomed, pleasant, and cordial. Social amenities were exchanged, and the nurse was graciously ushered in and seated.

NURSE. You look so nice. How do you feel? [The mother was five months pregnant.]

MOTHER. Well, pretty good now, although I'm so tired, especially my eyes.

NURSE. Your eyes? Do you have difficulty reading?

MOTHER. No, not exactly; my eyes just feel tired. My eyeballs are heavy. However, when I first became pregnant I had a complete check and at that time received new glasses.

NURSE. Do you see the doctor regularly?

MOTHER. Oh, yes, since very early in my pregnancy. I was very sick; I had shots and took some pills, but I'm not nauseated now.

NURSE. Did you have the same type of difficulty when you had your first baby?

MOTHER. No, in fact, I can't remember very well. You see that's seven and one-half years ago. I can remember being sick when I first got up in the morning, but that's all. This time, when I was so sick, Bobby would ask to go somewhere, and I'd tell him when mother feels better we will. But now we try to get out more.

NURSE. It is quite usual for children to be concerned if someone in the family is ill.

MOTHER. Well, Bobby is real good when I'm sick. He plays quietly by himself and doesn't ask for anything.

NURSE. Many children may even worry about their mother's health, especially if they have had related experiences.

MOTHER. Now that you mention it, I'll bet Bobby is worried. He has had so many odd things wrong with him and has been to several different doctors. Why, I'll bet the fact I go to the doctor so often makes him think I'm very sick, but then he never said anything. He's so young. Do you think a child so young bothers about how others feel?

NURSE. Yes, indeed, most children are aware of the feelings of those about them.

MOTHER. Probably Bobby is worried about my being sick, although he has never said a thing. [This was said very

thoughtfully.] The only thing he has said is that he didn't want the baby.

NURSE. He probably has, at least to him, a reason.

MOTHER. Yes, I suppose so. This is our fault because he used to ask for a baby all the time and we'd tell him, well, if you have a brother or sister you couldn't have this or do that. Bobby mentioned this, too. At first we sounded him out and asked how he'd like a brother or sister. He'd just say, "Nope, don't want any." Then one day I was tired and told him, "That's too bad, you are just going to have one anyhow." Now I think he likes the idea. Why, last week when we were visiting my sister we gave the children some money to spend at the dime store and do you know what they came home with? A pinning blanket for the baby, and it was Bobby's idea!

NURSE. Children can be very thoughtful.

MOTHER. Do you suppose our moving had anything to do with upsetting him? I've thought and thought and tried to figure out why he should be so tense. I'm so glad the teacher called me. Why, until she called me I had no idea anything was wrong. I've never seen any sign of tenseness or shaking like that at home.

NURSE. Moving, of course, is difficult for everyone concerned.

MOTHER. But then we just moved across the street, so he's in the same neighborhood with the same friends and everything. It's nicer here, too. We have more room and we're downstairs. We have a room we're fixing up for the baby. Bobby has helped with this and he seems real interested.

NURSE. Well, that is fine. Moving across the street certainly is easier than across town.

MOTHER. Yes, I was so glad we found this place because I was worrying about Bobby changing schools. He is very

shy, and it's hard for him to become acquainted. Even as a very small boy when we'd visit our friends, he would take a toy and play real quietly by himself in a corner. More than one of our friends have remarked about how good he was.

NURSE. Yes, I understand he is very quiet and coöperative in school also.

MOTHER. Oh, yes, he likes school now that he is acquainted. When he was in kindergarten, I had quite a time getting him to go in the morning. I had to take him every day for a long time. Then one day I didn't have to go to work and I had something I wanted to do, and I just shoved him out the door, literally. [She laughed.]

NURSE. You were working?

MOTHER. Oh, yes. I've always worked, that is since Bobby was about one year old. He stayed with my sister. His father worked from three o'clock to eleven o'clock at that time, so he had Bobby a great deal of the time.

NURSE. You are no longer working?

MOTHER. No, I was through about a month ago, well, the last of January, to be exact. That's why I can't understand this. Now that I'm home all the time you'd think if he had any problems my being home would help. I've even asked him, "Would you like mama to go back to work?" and he said, "Oh, no!" When he comes home from school he comes running in the house and calls, "Mama, mama?" checking to be sure I'm there. [The dog came to beg to go out.]

NURSE. You have a very nice cocker. Is it Bobby's dog?

MOTHER. Yes. I've even thought maybe that's his trouble. We have threatened to get rid of the dog.

NURSE. Dogs are a great deal of added work.

MOTHER. Yes, they are, but I don't mind them, really. We've always had a dog. What I mind is that Bobby doesn't always take him out when he should.

NURSE. Is he greatly attached to the dog?

MOTHER. Well, yes, he plays with him a lot and wants to have him around all the time. [The dog went to the boy's room and was put out.]

NURSE. Does he sleep in Bobby's room?

MOTHER. Oh, no! We keep him in the kitchen in the house. Bobby has his stuffed toys to sleep with and an old blanket he likes.

NURSE. Does he fuss or cry when you tell him you will not be able to keep the dog?

MOTHER. Well, one evening I heard him crying and I asked him what was wrong and he said, "Well, if I can't have Spot you'll have to get me another dog." So I don't think he thinks so much about this dog; it's just any dog. Maybe it has something to do with not being able to have what he wants when he has a brother and a sister. I just don't know. Probably I should take him to the doctor for a good checkup. He hasn't had one for a couple of years.

NURSE. Yes, I think that would be fine. Do you think he hasn't been feeling well lately?

MOTHER. No, no, he seems all right, but he has been complaining about his neck hurting him again.

NURSE. His neck?

MOTHER. Yes, when he was a baby about eighteen months old his neck hurt him so that he'd scream when you picked him up.

NURSE. How long did this last?

MOTHER. Oh, about three days severely, but he complained about it a lot, long after.

NURSE. What did the doctor say?

MOTHER. Well, it was so long ago, but he didn't mention polio, but maybe it was because of his eye. You see, one eye doesn't focus. The muscles are frozen to the eyeball and the other one would turn way in. They wouldn't operate then, not until he was four years old. The doctors said no doubt he

was seeing double. Of course, now that is corrected, and he is examined every year.

NURSE. When his neck hurts is there any prescribed treatment?

MOTHER. Well, no. Of course this doesn't occur often anymore. Then, too, he has a foot condition. He said his heels hurt him. The doctor sent us to a bone specialist for that, and that doctor told us he had cysts on his heels. They took X rays and all, and he still wears a special type of shoe (a shoe with inner sole and heel, wedges one-eighth inch). I should have that checked again, too; but I've been feeling so badly, things like that just haven't been done.

NURSE. Does he complain of his feet hurting?

MOTHER. No, but then he doesn't tell me anything any more. When I ask him about school, he says, "Oh, fine," or what he did in school, "Oh, nothing."

NURSE. Most children demonstrate this need for independence and growing up from time to time, that is, they will keep some things to themselves.

MOTHER. Maybe I've been asking him too much, but I want him to know I'm interested in what he is doing.

NURSE. Have you had a chance to talk this over with your husband?

MOTHER. Oh yes, we discussed it last night. He was very surprised, too. He hasn't noticed anything at home either. What do you suppose it is?

NURSE. It appears to be a physical movement which brings about some conscious satisfaction. Bobby appears to be very tense and absorbed through the entire process. Think of it as a nervous habit such as fingernail biting or thumb sucking.

MOTHER. You mean he'll outgrow it?

NURSE. It is not exactly a process of outgrowing. Maybe it could be thought of as a period in growth where a child

needs more understanding and/or attention than he has had up to this time. Most people, grownups as well as children, need to feel very dependent at times but at the same time we struggle to be independent—an individual.

MOTHER. Do you think we expect too much of Bobby?

NURSE. I couldn't possibly answer that question, but maybe you and your husband will do so, or maybe some specially trained help like the personnel of the child guidance clinic would be of help to you. I would like to leave some of this literature with you; probably it will be of some help also.

MOTHER. Thank you. I think that Bobby is worried about me and the new baby. Maybe I should tell him I'm not sick.

NURSE. Oftentimes people are afraid of things simply because they do not understand them.

MOTHER. Maybe I should explain about my visits to the doctor as regular routine for mothers.

NURSE. Yes, I think that would be good. [The nurse stood up, as it was close to the time Bobby would be home from school.]

MOTHER. You know, Nurse, I feel better. You know, we only want to do what's best for Bobby.

NURSE. Of course you do. If there is ever anything or any way I can be of service to you, I would be very happy to do so.

MOTHER. Good-by, and thank you very much.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF BOBBY

Interviewing Based on Understanding Behavior.—The process of professional interviewing depends on an understanding of human needs and fundamental principles of behavior. In connection with the Case of Barbara, some of these needs and behavioral principles were highlighted. They should be reconsidered in relation to the following discussion on interviewing.

Definition and Goals of Interviewing.—Interviewing involves a process of interaction and communication between people. Through this process individuals can mutually clarify feelings, attitudes, and meaningful information. In this way professional people can gain increased understanding of the behavior and personal reactions of individuals they serve. The interviewing process can determine the way these individuals perceive their own problems.

Skillful interviewing is the means through which an integrated understanding of people is combined with the knowledge of one's own professional field in order to enable the patient to help himself. He is helped to arrive at a clearer view of himself in relation to his current concerns. With this understanding he can work toward a constructive and meaningful plan for himself.

Skills Involved in Interviewing.—Interviewing requires skills not only in the use of words but also, of equal significance, in understanding the meanings behind the words as well as the meanings of nonverbal reactions. In addition, there are other intricate skills and sensitivities involved in interviewing. These include the following: (1) the use of language appropriate to the individual interviewee and the particular situation; (2) timing—when to say something and when to listen; (3) recognizing what the interviewee needs, wants, and is ready for in relation to the professional service being offered; (4) maintaining a professional, objective attitude. (See Basic Principles Illustrated in the Case of Jerry.)

Since interviewing involves interactions of people, the process can be neither simple nor mechanical. There are no preconceived formulae nor easy rules to follow. On the other hand, interviewing skills can be developed and sharpened deliberately by (1) continuously studying and applying knowledge of the growth and development of human beings; (2) continuous study of self and one's own attitudes and

needs in giving service to others; (3) frequent exercise in translating the words and reactions of patients or clients into the intrinsic meanings of causes, needs, and motivations.

Some Conceptual Guideposts in Interviewing.—All professional interviewing must be guided by the recognition that human beings throughout life strive to maintain for themselves an adjustment balance, or *homeostasis,* which is ever shifting and ever changing. The balance may be shaken or upset when the individual has to contend with that which is unknown or unacceptable or not understood. In other words, each person must assign some meaning, which he can digest or tolerate, to all his experiences so that they can become part of him as a person. A line-of-least-resistance way of trying to contend with vague or intolerable experiences is to give them more definite and simpler form, i.e., by categorizing and labeling them "good" or "bad," "right" or "wrong," "wise" or "foolish," "reasonable" or "unreasonable." This sort of defense against threat avoids facing reality and blocks a true understanding of the causes and meanings of one's reactions. The interviewer, aware of the pitfalls of focusing on labels and symptoms and knowing that behavior always has understandable causes, can help the patient gradually differentiate between reality and the confusions created by defenses.

SOME QUESTIONS FOR DISCUSSION

1 Discuss this type of referral to the public health nurse. What is the nurse's role in this situation? What helps her to determine her role and her limits? Compare this referral with the referral in the Case of Lester.
2 How does the nurse's understanding of people influence how she handles this interview? What helps us to understand behavior?
3 Discuss and compare the teacher's and the nurse's views of the child's situation.

4 Compare this interview with the one depicted in the home-visit scene in the film "Broken Appointment" and the interviews in the Case of Barbara.
5 Discuss the behavior that is characteristic of a seven-year-old as he grows, develops, adjusts, and relates to others. What are some of the factors that need to be considered when generalizing about the behavior of any age level?
6 What is the nature of the relationship between the child and the mother? Between the child and the teacher? Between the nurse and the mother? Discuss how their interactions illustrate some of the behavioral concepts described in the Basic Principles.
7 Discuss the consideration of referral to the child guidance center by the nurse. Interpret her procedure.
8 What principles of anticipatory guidance are illustrated in the nurse's efforts with the family in regard to the expected baby?
9 When a parent becomes ill, what are some of the natural reactions of a young child?
10 Discuss what you consider to be the nurse's responsibility in this case for further planning in relation to the family, the teacher, and other agencies.

REFERENCES

1 The American Public Health Association, Inc. *Health Supervision of Young Children.* New York, 1955, pp. 45–65.
2 Caplan, Gerald. "Psychological Aspects of Maternity Care," *Some New Approaches to Maternity Care,* Washington, D.C.: Reproduced by U.S. Department of Health, Education and Welfare, Children's Bureau. Sample copy free.
3 Garrett, Annette. *Interviewing: Its Principles and Meth-*

ods. New York: Family Service Association of America, 1958, pp. 26–75, 121–23.

4 Mohr, George J. *When Children Face Crises.* (Better Living Pamphlet.) Chicago: Science Research Associates, 1952, pp. 11–26.

5 Schmahl, Jane A. "The Price of Recovery," *American Journal of Nursing,* LVIII (January, 1958), 88–90.

6 Wolff, Ilse. "Interviewing in Public Health Nursing," Parts I and II, *Nursing Outlook,* VI (May, 1958), 267–69; and (June, 1958), 320–22.

DISCUSSION AIDS

Films:

"Family Circus," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 7 minutes.

This film explores the "normal" rivalry feelings of children, and the often resulting dismay of parents in regard to a child's outward expressions of them. It clarifies universal communication problems between parents and children.

"Broken Appointment." For a description of this film, see Chapter IV.

"A Long Time to Grow, Part III, Society of Children—Six-, Seven-, and Eight-Year-Olds." For a description of this film, see Chapter VI.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Mrs. Davis Episode." See Chapter IV for a description.

VIII

Primary Prevention as a Public Health Focus

CASE OF CARL

At the time of this study, Carl was a boy of thirteen. He was the youngest of four children, the others including a girl born in 1918 and two boys born in 1916 and 1925. The father was a farmer and the family lived on rented farms until 1949, when they bought and moved onto their own farm. The farm buildings were in good condition and well cared for. The home was neat, clean, and comfortable. The older children were married and living away from home. The parents were friendly, but frustrated as to how to handle Carl, who had become a problem in school attendance and also in discipline. Carl went to school quite regularly until the spring of 1947; from then on he had refused to go to school.

Referral.—The teacher reported to the nurse in the spring of 1947 that Carl was missing school apparently for no reason, and she would like to have the nurse make a home visit to see if there was a health problem. She stated that he was very nervous but not a problem in school, and when there, he seemed to be quite happy. A home visit revealed

that he just did not want to attend school, and apparently the parents were unable to make him attend.

The nurse had known Carl and his mother since his birth in 1937. At that time his mother brought him to the infant and child health centers. He was a problem child at that time. The doctor had difficulty in examining him—in fact, all who worked with him at the center were happy to see him leave, as they had to put up with crying and fighting from the time he entered until he left. After starting to school, he was not a problem to teacher or pupils. He did slow, average work and took his place in class and on the playground without too much confusion.

In the summer of 1947, the nurse made a home visit to see how plans were working out for school. Carl and his parents had gone to Illinois to a funeral, but a daughter-in-law who lived in a trailer in the yard was at home. She stated that Carl had to have his way in everything or he went into tantrums. She said that he was planning to go to school but that his mother could not get him to read or do anything that pertained to school.

In October, 1947, the teacher came to the nurse's office and stated that Carl had started to school, but that he was already missing a great deal and that he seemed to have a great fear of something. His mother had come to school with him for a few days, but he would not stay in school unless she stayed with him.

The nurse made a home visit. Carl was in the farmyard as she drove in, and before he had time to realize who she was, she called, "Hello, Carl. How are you today?" He responded, "Hello, I have a cold." By this time the nurse was out of the car, so she answered, "I see you have, and I am happy to know that you are observing the health rules by staying at home and not spreading cold germs in school. This is a beautiful day, but don't get chilled." He answered,

"I am warm enough." The nurse said, "How is school?" and getting no response, said, "What is there about school, Carl, that you don't like?" He stated, "Arithmetic." The nurse said, "Well, I think we can help you with that. You know, Carl, all of us find that some things are harder for us to do than others; but by keeping at them and having some help, we conquer them and get along all right. How would it be if I ask your mother to help you with arithmetic? Would it be O.K.?" He said, "O.K.," and they went into the house together.

The nurse talked with his mother about his cold and then about his trouble with arithmetic and asked if she could find time to help him with it. She stated that she could and would. While Carl stayed in the house, the nurse kept the conversation on general matters, and soon he tired of listening and went out to the barn. Then the mother stated that she had been trying to help him with his arithmetic but that he refused to coöperate in any way with her. The nurse asked why he had started staying home from school. The mother stated that the short way to school was through the woods, and that they and some of the neighbors had been hearing an animal cry at night which sounded like the cry of a lynx, and that he was afraid to go through the woods. The nurse then suggested that they take him to school around the road, that it would pay them to do so, and he would probably get over his fear. The mother indicated that she had taken him to school through the woods for a few days, but that he wouldn't stay in school without her, and that she didn't have time to go to school every day. "Besides," she added, "I am afraid to go through the woods myself." She then remarked that they had ordered a bicycle for Carl and that it should be there the next day. Then he could ride to school around the road. As she left, the nurse

advised getting him back to school as soon as his cold was better.

When the nurse was leaving, Carl rode up to the mailbox with her, and on the way the nurse talked about the birds and different animals that live in the woods, thinking that he might mention the lynx, but he didn't. When he said good-by he stated that he would soon be riding his bicycle to school. The nurse stopped at the school as she went by and told the teacher about her call and that he would soon be back in school. The nurse inquired if the teacher and Carl had had any trouble and if he feared her in any way. The teacher replied that as far as she knew he had no fear, that he was always friendly, and that their farm joined Carl's parents' farm, that they exchanged work and Carl came to her home and was always very friendly. The teacher spoke of the lynx and said that some of the neighbors had seen an animal that resembled a lynx, and that the cry they had been hearing at night was enough to frighten anyone.

The bicycle came in a few days and Carl returned to school for a few days. Then he quit and his parents couldn't get him to return. He refused to do any schoolwork at home. The parents became very much concerned about him as they found him handling a rope down in the barn, and they were afraid that he was planning to hang himself. It seems that a short time before they moved onto that farm, the man who had lived there had committed suicide by hanging and that Carl lived in fear that the man was still around there. The nurse suggested that since he had so many fears on this farm, it might be well to move away from that vicinity.

When the parents again found Carl down in the barn playing with the rope, they took him to the family physician who made an appointment for them to take him to another city to a specialist. They weren't sure what kind of specialist

he was. However, they did not keep the appointment. Finally, they took him to the clinic in the city and were given some medicine for him. The mother thought it constipated him, so she stopped giving it to him but did not go back to the clinic. They did go back to the family physician who advised keeping him out of school for the year. The teacher made a home call and asked the mother if she would like to have the nurse call. The mother stated that Carl had become very shy with strangers, and she thought it best for the nurse not to call. He ran and hid whenever he saw a car drive in.

In the fall of 1948 when school opened, Carl would not go back to the district where he belonged but did consent to go to the adjoining district school. The first day went fine. He got his lessons, took his place on the playground, and made an appointment to meet one of the boys at the factory the next morning to ride on from there together. However, the next morning when his mother called him to get started to school, he stated that he was not going to school. She begged and pleaded with him and then threatened to punish him, but he went down to the barn and did not come back to the house until after the men had gone back to work after dinner. She had searched the barns and called for him but could get no answer. The next morning he arose early before his parents were up and hid somewhere until midafternoon. He continued to do this for quite some time. The nurse asked about food and the mother stated that from the way she arranged rolls, etc., she could tell that he was taking some with him. She said he never made any noise or confusion when he got up so they didn't hear him.

In November, the nurse invited the mother to bring Carl to a clinic at which a psychologist was to be present. The nurse explained that no doubt the psychologist could help

them in knowing how to handle Carl. The mother doubted that she could get him to attend but she would try. They did not attend. Since Carl hid every time a car drove in, there seemed to be little point in having the psychologist try to make a home visit.

In the fall of 1949, the family moved into a new district and the teacher in that district was ready to accept the challenge and was going to make a great effort to keep Carl interested. However, Carl refused to go to the home district and started to school in the neighboring district. He got along there very well. The school was small and the teacher had time to work with him. She arranged to have him recite with a youngster who had missed a grade, and when the nurse visited the school she was delighted with Carl's behavior. She was quite convinced that this time he was really going to stick. He was very friendly with the nurse and wanted her to visit his class. He took part on the playground and was, in general, a normal boy. However, in early November Carl decided that he would not go to school and he quit. Neither the parents, teacher, nor supervising teacher could get him to return. He would either hide or go to bed and say he was sick.

In the fall of 1950, he did not start to school, so the supervising teacher and the nurse made a home visit together. Carl was in the barnyard with his father and some men who were whitewashing the barn. When he saw the car drive in, he ran and hid. The father told the teacher and nurse that his wife was in the house and to go right in. She was very cordial. The supervising teacher explained the school laws to Carl's mother, and she said she knew them and had been expecting someone to call on them for not sending him to school. The nurse told her that since they were unable to keep Carl in school, it might be wise to have a psychiatrist see him, and that she would be happy to help her make

plans for this type of care. The mother wondered if there was something wrong with his mind, and she agreed that they should see a doctor about it but said that they would make arrangements through the family physician.

The supervising teacher said that they would be given a week to get him examined and to report to the office as to why he should not attend school. In a few days the father called the office of the County Superintendent of Schools to inform him that they had been unable to get an appointment as yet but expected to have one soon. The nurse contacted the superintendent at intervals to inquire about the report received, but the report never came in. Finally the nurse called the mother and asked if they had taken Carl to a doctor. She stated that they had taken him to Dr. X. and another doctor, whose name she could not recall. Carl had been in bed for weeks and was not fit to be in school or anywhere. The nurse inquired as to his trouble and the mother replied, "Nerves, I guess." She added that they had had a very hard winter as the road into the farm had been filled up most of the time with snow and that the water pipes to the barn had frozen so they had been obliged to carry water for the horses, cattle, and pigs. After talking to the mother the nurse wrote to Dr. X. (a copy of the reply is attached).

The nurse feels that the work on this case really has done little good because it has not been followed through. The family physician, who had cared for the mother before and after Carl's birth and until 1948, died at ninety-two years of age. Although the suggestions made by him for special care were good, he did not follow through with them, probably forgetting about the boy until the family, prodded by the teacher or nurse, went back to him again. He still did not follow through.

It would seem a psychiatrist should take over and if possible get this boy away from his home environment and to a place where he would have kind but stern treatment.

Letter to Nurse from Psychiatrist

Re: Carl

Thank you very much for your letter of January 31 concerning Carl.

He was seen briefly on 10–18–50 and 11–1–50. His past history was essentially negative except for measles in infancy and possibly also whooping cough. The chief complaint on admission was that of the mother, "I can't get Carl to go to school." She stated that he had not been right since infancy, that he developed more slowly than other children but could not say at what age he first walked and talked. He has always been rather nervous, unable to sit still and if kept in school is likely to throw up and has to be sent home. His general knowledge appeared to be somewhat scattered, but partly accurate, and he has apparently acquired some facility in the use of his hands or in the doing of mechanical things such as woodworking and tractor driving.

On examination, his weight was 90 lbs., height 5′1″, blood pressure 108 systolic, 64 diastolic; pulse and temperature, normal. The tonsils were apparently somewhat enlarged. He was apparently bashful and said "I don't know" in answer to a number of questions and exhibited peculiar mannerisms or movements of the face and shoulders.

It seemed possible that he might be suffering from an old birth injury or a possible encephalitis, e.g. from the measles at 1½ years of age. He was not here long enough to obtain laboratory test or much consultation. It is possible that there are factors in the home which might influence his behavior but I was not made aware of these. It would probably be well if he were observed further under hospital conditions or his situation might be discussed with the State Board of Education in order that arrangements might be made to try him in special classes. It would seem more or less futile to insist on his attendance at regular public school classes until situation is studied further.

I assure you of our desire to cooperate with respect to this boy.

Very truly yours,
———, M.D.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF CARL

Preventive Public Health.—Preventive public health is based on the following: (1) strengthening all people throughout their development, with special emphasis on the early years; (2) reducing environmental hazards; and (3) starting casefinding early and initiating early appropriate treatment. The preferred emphasis of preventive public health is not on amelioration of manifest symptoms but rather on broad epidemiology, etiology, and immunology. The effectiveness of public health in achieving its various objectives depends significantly on how well public health workers understand and apply a valid knowledge of human behavior.

The Nature of Symptoms.—The Case of Carl depicts the progressive difficulties in the adjustment of a boy from infancy to adolescence. Prominent among the symptoms is his painful aversion to leaving home in order to attend school.

Symptoms always are expressions of discomfort, conflict in one's feelings, or unmet needs. Symptoms are usually expressed indirectly because the person cannot ordinarily modify the causes and cannot easily face or understand the source of the difficulties. The lack of a direct logical connection between symptoms and causes makes it difficult for the patient and the professional worker to gain an accurate picture of the cause of the trouble and what it really means. Without sufficient understanding and appropriate situational modifications, symptoms will persist, return, or undergo substitution by other symptoms. The focus on the

symptom of Carl's failure to attend school beclouded the real issue of why he could not leave home. The difficulties he presented at the infant and child health centers distracted attention from the more significant questions of causes and meanings of his unpleasant behavior.

Multiple, Cumulative Causation.—As we increase our understanding of the nature of behavior, we become more aware of the fact that personal maladjustment always arises from multiple causes rather than any single cause. The nature of one's relationships with other people is a basic factor in causation. Problems may become progressively more complicated and aggravated because of the unresolved difficulties in interpersonal relationships.

Primacy of Prevention Despite Problems and Pressures.—By being aware of the general patterns of human development, needs, and adjustment, we can better recognize what are typical points of stress inherent in everyone's growing-up experiences. These stressful periods can be eased through various public health preventive procedures. Understanding patterns of human growth, knowing the nature of universal points of stress, and having applied appropriate preventive measures, the nurse can more precisely determine when she can be of most help to families or when they will need other resources. No one discipline or agency can or is required to deal effectively with all problems. Often teamwork among agencies will provide the most suitable service. (See the Case of Ruth.)

The nurse has deep concern for people. She is under pressure of time and the compelling urgency of many problems requiring solution. Thus, a large proportion of her time can be siphoned into repeated attempts to work with the surface aspects of symptoms rather than focus on the person himself and the causes and meanings of his behavior.

Professional persons working with human beings are very often caught up in a serious dilemma. They have to be practical and expedient while at the same time trying to safeguard the patient's rights, feelings, needs, and long-range values. Despite pressure for expediency, time and energy applied to the development of educational procedures for prevention and to early recognition of universal problem areas can in the long run prove practical as well as most helpful to the patient.

SOME QUESTIONS FOR DISCUSSION

1 To what extent can a professional worker enter upon a home visit with objectivity? To what extent did the nurse function objectively in her visits to Carl's home?
2 What are some of the broad objectives and goals of service to any patient? How do these apply in Carl's case?
3 How do we learn to see the problem as the patient sees it? Discuss the ways the nurse tried to see the problem as Carl saw it. As his parents saw it.
4 What are the basic preventive procedures in a well-baby clinic? What constructive plans might be made for a child like Carl at such a well-baby clinic?
5 What may be the meanings to Carl of the difference in age between him and his siblings? To his parents?
6 Cite clues to describe Carl's relationship to his parents.
7 What do you understand "the team approach" to mean? What is meant by the term "splintering" of services? Discuss these terms as applied to this case.
8 What are some of the similarities and differences in interviewing techniques with adults as compared with children?
9 How do you think the nurse felt regarding her role in this case? On what do you base your conclusions?

10 What are some of the meanings to any child of being separated from his parents? What are some of the meanings to the parents of being separated from their child? What do you feel being separated from his parents could mean to Carl?

11 Point out the ways that the parents and nurse actually lost time by treating Carl's symptoms. How do you think Carl felt about not attending school?

12 Discuss the nurse's evaluation of progress in working with this case as summarized in the last two paragraphs of the case study.

13 What do healthy learning and adjustment in school require of any child?

REFERENCES

1 The American Public Health Association, Inc. *Health Supervision of Young Children.* New York, 1955, pp. 66–79, 95–135.

2 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 26–81.

3 Cameron, Norman, and Ann Magaret. *Behavior Pathology.* Boston: Houghton Mifflin Company, 1951.
On focusing on symptoms, see pages 558–59.

4 Caseley, Donald. "Trends in Medical Practice—Their Implications for Nursing," *Nursing Outlook,* V (May, 1957), 300–302.

5 Hearn, Gordon. "A Social-Psychological View of Nursing Service," *Nursing Outlook,* I (November, 1953), 632–33.

6 Lippman, Hyman S. *Treatment of the Child in Emotional Conflict.* New York: McGraw-Hill Book Company, Inc., 1956.
On meaning of separation, see pages 4 and 99–100.

On "The Child with School Phobia," see Chapter VII.

7 Rives, Ruth. "Priorities According to Needs," *Nursing Outlook,* VI (July, 1958), 404–8.

8 Ross, Helen. *Fears of Children.* (Better Living Pamphlet.) Chicago: Science Research Associates, 1951, pp. 3–38.

9 Symonds, P. M. *Dynamic Psychology.* New York: Appleton-Century-Crofts, Inc., 1949.

On meaning of separation, see pages 121–23. On focusing on symptoms, see page 397.

10 Taylor, Margaret, and Claire Bartholomew. "Stress Factors in Caseholding," *Nursing Outlook,* IV (May, 1956), 276–78.

11 Towle, Charlotte. *Common Human Needs.* New York: National Association of Social Workers, 1952, pp. 37–45.

DISCUSSION AIDS

Films:

"Over-Dependency," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 32 minutes.

This film shows how the natural drive toward independent development can be hindered by different experiences in childhood when adults have not understood the meaning of the child's needs. Illness in childhood may interfere with growth toward independence and set a pattern for the use of physical complaints to escape from the pressures of reality.

"Fears of Children," International Film Bureau, 6 North Michigan Avenue, Chicago 2, Illinois. 30 minutes.

This film clarifies the nature of children's fears. It indicates that fear is natural for children as they have to

adjust to a complicated world of reality. It suggests the importance of interpersonal relations with children and others as they affect the way a child learns to adjust to threatening and frightening experiences.

"First Lessons," International Film Bureau, 6 North Michigan Avenue, Chicago 2, Illinois. 20 minutes.

This film affirms that teachers must understand both themselves and human behavior generally as a basis for effective teaching and that children need to understand their own behavior and that of others as well. It is related almost entirely to the relationships within the classroom but suggests that experiences at home affect significantly what happens in the classroom and vice versa.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Karen Green Episode," Educational Aids, Brooklyn, New York.

Part I: An insecure student nurse increases anxiety in a child at the time of separation from the parent.

Part II: A senior student nurse helps the child and the parent to separate by permitting them to participate in the planning.

Part III: The senior student nurse helps the child to accept hospitalization and a tonsillectomy by meeting the immediate needs, thus making way for more mature needs to emerge.

IX

Interagency Coöperation in Serving Families with Multiple Problems

CASE OF RUTH

The father works in Sometown. Donnie, age ten, lives with his grandmother in Colorado. Ruth, age eight, and John, age five, live with their mother in Bay City. The father sends money home to the family. The mother sells cards and cosmetics.

Ruth is in the fourth grade in the public school. She wears two double-bar long leg braces and crutches as a result of poliomyelitis. The nurse saw Ruth the first time at school. The next time the nurse was in the home when Ruth came from school. She came in quite excited telling about the fire in one of the schools the previous day. She told some pretty exaggerated stories about the children's clothes catching on fire, etc. The mother promptly stopped her and told her not to be telling such things. The nurse told Ruth that she had on a pretty skirt, and she seemed pleased with a little praise. The mother carried the conversation.

Referral.—Through a neighbor, the nurse learned that Ruth's brace was broken and the neighbor did not think the mother knew how to go about getting help. This was a year before referral. The nurse made a home call and found John locked on the porch. Another five-year-old boy, whose mother worked, was at the outside door. Ruth's mother was supposed to be caring for him; instead she was out selling cosmetics. The nurse made a home call later and found her home. She had been in touch with the local chapter of the Infantile Paralysis Association and had the brace fixed. She asked if she could come to the office and talk with the nurse. The following week, the mother came to the office, as arranged.

Ruth was presenting a problem at school. She was incontinent at school and at home. She was stealing from the students in the classroom. The children were taking quite a dislike to her. She was stealing money from her mother and getting at the cab drivers' coin exchanges. The cab drivers couldn't put her in the back seat because she wouldn't sit down and would fall, and they were afraid she would hurt herself. When her mother would give her a nickel for Sunday school she would change it to pennies at the store and only put in a couple of pennies. She had an unnatural craving for sugar and would eat it by the handful when her mother was not present. She lied about things to her mother and the teacher.

About the same time a letter came to the nurse from the State Agency for Handicapped Children indicating they had a letter from the Superintendent of Schools complaining of the same problems the mother had described.

Polio had come on five years before while Ruth was visiting her maternal grandmother in Minnesota. She was admitted to a Minnesota hospital immediately and to the Kenney Institute four months later. There was practically

complete loss of function of the lower extremities with generalized weakness in the trunk. She received intensive treatment but retained complete loss of function in the left leg and loss of function in the right leg except toe flexors. Her trunk muscles improved. The child was fitted with two long leg braces two years after onset. She was discharged from the Kenney Institute one month later walking with braces and crutches. Before and after Ruth's return to her family in Sometown a month after discharge—during the interval she stayed with her grandmother in Minnesota—the Sometown County Welfare Department worked with her parents. Arrangements were made for her to attend the orthopedic school in Sometown for academic work and walking training.

Ruth reported to the S. Hospital in Illinois in the fall, where she had her right heel cord lengthened.

The social picture was complicated by parental discord, friction between in-laws, and rejection of Ruth and Donnie. The mother and father were in poor health, and housing facilities in Sometown were unsatisfactory.

The mother moved to Bay City with the children because of poor housing conditions in Sometown. The home in Bay City had been left to her by her grandparents, and there was still a mortgage on it. Donnie, Ruth's older brother, is an asthmatic. He was living with his grandmother in Colorado. The mother stated that Ruth and Donnie did not get along and fought all of the time. She explained that Ruth received so many attentions and gifts while in the hospital with polio that Donnie felt very much neglected.

When the Superintendent of Schools wrote to the Handicapped Children's Service, they wrote back saying they would make a call in two or three months. The nurse wrote to the Service telling them she felt it was a very serious problem and that if they could make a call sooner they should do so.

The Service felt that the medical social worker would be the best one to see the case. A month after the nurse wrote, the medical social worker from the Handicapped Children's Service and the nurse made a home call together. They had a long visit with the mother. She was very willing to talk, and through the entire conversation one got the same picture: "Because of Ruth I have to have an operation." "Because of Ruth I was on the verge of a nervous breakdown." The mother was asked whether the children missed their father. She stated that he was mean to the children, particularly to Donnie, the older boy. The mother "knew all the answers." It had been suggested that Ruth might go to the orthopedic school and be home week ends. This was ruled out because no more treatment was necessary, and she should be in public schools to adjust and get along with other children. The worker did not mention a foster home, but just before they left Ruth's mother wanted to know about putting Ruth in a foster home.

Every suggestion the social worker made was met more or less with opposition. Following are some examples:

SOCIAL WORKER. Do you let Ruth have some hand lotion for her chapped hands?

MOTHER. I did once and she spilled half the bottle. She does not rinse the soap off her hands. That is why they are chapped.

SOCIAL WORKER. Have you tried giving her an allowance?

MOTHER. No, I buy whatever she needs.

SOCIAL WORKER. Have you talked to Ruth and explained to her how the things she is doing will make her lose friends?

MOTHER. Yes, but she doesn't pay any attention. I am afraid to take her in stores with me for fear she will take something and embarrass me.

SOCIAL WORKER. Have you rewarded or praised her when she has done something exceptionally well?

MOTHER. Yes, but that didn't help any.

SOCIAL WORKER. Have you taught Ruth to do tasks around the house?

MOTHER. Yes, but she is so sloppy I have to do her work over. She can do better if she wants to.

All during the visit the mother kept reprimanding John, the younger brother. He paid little or no attention to her.

The social worker and the nurse also talked to the minister of the church. This has not been the family religion, and it is not sure why they started going to this church. The church tried to help the family. They picked Ruth up for church on Sundays and included the mother and brother in their group activities. The five-year-old boy was quite a behavior problem at church, but later began to do better. The minister was very willing to coöperate in any way he could. It was agreed the mother needed help as well as Ruth.

The beginning of the following year the nurse received a letter from the medical social worker, the contents of which were as follows:

I thought you would like to know that I was still quite concerned about Ruth and wondered further about the questions we had posed as to how long patient should be exposed to the present extreme rejection by her mother. Upon returning to the city I reviewed the case situation with the Child Welfare Authority and they have agreed to assist in planning for Ruth with placement outside the home, perhaps. This will be a slow process and they too thought in the meantime the minister could be of greatest help in the situation. The minister might like to know that Ruth's father is a Catholic but the parents were married by a Justice of the Peace and the children have never been reared as Catholics nor to our knowledge has the father adhered to his religion. The marriage, however, was never really acceptable to either set of in-laws.

Our records failed to reveal further information about patient's father except that he had an asthmatic condition and was highly nervous. However, the history as obtained from the Sometown County Welfare Department stated that Ruth's mother's father died when she was 22 months old and that there has always been a great deal of antagonism between her and her mother. It is indicated further that her childhood was an unhappy one.

Ten days after the nurse received the letter from the social worker, Ruth was admitted to the orthopedic hospital for treatment of swollen legs and infection and to have her braces fixed. Less than a month later the nurse took Ruth to the hospital for a fitting for a back brace.

The mother observed that when Ruth came home from the hospital each time she behaved very well for a couple of days.

The teacher was very patient with Ruth and tried to help her. But the nurse feared the teacher would lose patience with the child because she told fibs and tall tales and was always presenting some problem.

The medical social worker referred this case to the state child welfare worker at the beginning of the year. The nurse had previously talked with the local child welfare worker about the case. She did not make a home call. Two months later, the local child welfare worker told the nurse she had just received a letter from the state agency asking her to check the case. She planned to do so in the near future.

Donnie, the older brother, came back home when the grandmother had to leave Colorado. He was put in the same grade as Ruth, but in a different school. The nurse was called to Ruth's school by the teacher the other day to look at a cut on her head. Donnie, the older brother, had thrown a shoe and had cut her. It was a large scalp wound and the nurse felt she should see a doctor. The nurse went

to the house and told her mother. She made arrangements to take Ruth to the doctor. The nurse asked the mother how Ruth was doing, and she very quickly replied that things were no different.

In conclusion, the nurse wondered whether she should perhaps have written the case history about the mother rather than Ruth, but it was through Ruth that the case was brought to the attention of the public health agency.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF RUTH

Meanings of Handicaps.—In our culture a handicap carries special meanings. On the one hand, it poses a threat to our usual desire for perfection, which is frequently a competitive drive. A handicap may be regarded by both the afflicted person and by others as punishment and thereby it may be associated with guilt. On the other hand, the cultural support of fair play and full opportunity for everyone results in special consideration for those who are disabled.

Disability in a child is particularly intolerable in our society, which cherishes youth and banks optimistically on the future. There is apt to be a heavy reliance placed on seeking solutions to the problems of the handicapped that do not pay enough attention to the whole person, especially the individual's self-concept. He has not only to face the hard reality of the handicap but also to adjust his feelings and emotional needs to this reality in such a manner that he can (1) feel worthwhile as a person; (2) feel that he is not too different from other people or too inadequate to compete with others in some degree and in some way; and (3) maintain a fair balance in relationships with others without unusual dependency, undue resentment, or too much denial of natural feelings and reactions.

Focus on Actual and Potential Strengths.—In providing

service to families with problems, professional workers may become preoccupied with negative factors, that is, the pathology in the situation. Yet, for the sake of the particular people being served as well as the community as a whole, a very different focus is possible and desirable. This focus should be on seeking what actual and potential strengths there may be in the family despite their many difficulties. In other words, this positive focus tries to find out how the family or its individual members are able to function as well as they do under the given trying circumstances.

In this case the child-patient and her family have experienced multiple difficulties over a long period of time, some of them repetitiously. Despite resulting disruptions, they have managed to maintain some degree of family living. Most people when confronted with difficulties in their life situations attempt by themselves to work out solutions they feel are reasonable and satisfactory. This working out of solutions independently requires a heavy investment of effort and emotional energy in order to deal with the conflicts and problems involved. Clear and effective solutions are more likely to be achieved with less strain and frustration if there is available the help of adequate professional services.

Agencies Working Together.—In family situations which require the coöperative services of the public health nurse and workers from a variety of other agencies, it is vitally necessary that each of these workers define clearly his functions and how they relate to the functions of the other workers. Functions of agencies and professional workers need to be based on a shared understanding of people and their needs and of the way in which people develop, learn, and adjust. With this increased understanding of human beings, their needs can be more adequately met and there is less chance of confusion, incoördination, or gaps in

service. Professional workers and patients need to recognize that all the agencies are striving together for the common purpose of meeting people's needs. If the focus is on the person and meeting his needs, agencies can more clearly define their functions and can be more flexible in adapting services. Thus, long-range, coöperative services of several agencies to the same family may be worked out so that the particular service each agency gives at any one time can be shared with or shifted to other agencies to suit the family situation as it changes.

Effect of Attitudes on Service.—The way the public health nurse uses other agencies or the way they refer cases to her depends not merely on the actual resources available, but also on the attitudes and concepts of each worker in relation to health and illnesses. The families who receive service also have their own attitudes and concepts regarding health and illness. How efficiently and effectively the various community agencies can work together depends in considerable measure on the interactions of these attitudes and concepts between workers and the families they serve. Consider these examples: (1) a nurse who feels that in illness people should be completely dependent on a rescuing professional agency; (2) a welfare worker who believes that families with illness should not be coddled, especially since there is sometimes malingering and attempts to profiteer from public help under these circumstances; and (3) a family that feels ashamed and guilty because of poor health but cannot help itself or accept the attitudes of either of the two community agencies—the one that intensifies its shame and pushes it to take care of itself or the one that threatens any measure of independence the family still has and needs to maintain.

Interpersonal Factors in Working with Patients.—It is to be expected that patients will waver between wanting

to be independent and wanting to lean on someone who they wish could provide ready-made solutions. This strong need for help is likely to charge off a very sympathetic reaction in the nurse who will then feel she must provide at least some momentary relief through a ready-made solution. There is also a risk that the professional person may overidentify with either the child or the parent through this process of sympathy.

The professional worker often encounters a dilemma. Filled with good intentions for the patient, she may become involved herself. Yet she may run head-on against certain factors which may at best make her task very difficult and at worst undo all her purposes. These factors include the following: (1) The current practical situation of the patient cannot be separated from his entire life experiences, past and present. (2) The professional person's past experiences and reactions are involved in relation to the patient and yet have to be understood by the professional person and dealt with objectively. (3) The events of the patient's life, the facts surrounding the illness or disability have to be understood in terms of feelings and meanings to the patient. (4) Every individual has the need to contribute as much as possible to the solution of his own problems. (5) The professional person, the workers in other agencies, the parents, the child each has a fundamental need to feel that his own interaction with other people is reasonable and acceptable behavior.

This dilemma brings into play a variety of defense reactions not ordinarily under conscious control. It is possible to work toward resolution of this dilemma since one can learn to understand the defenses and other psychological factors involved. Through such understanding one can help attain practical and sound solutions to specific problems. This concept is also discussed in the Case of Bobby.

SOME QUESTIONS FOR DISCUSSION

1 Why is the home visit basically important in public health nursing? Discuss some of the problems in home visiting. Discuss the relationship between home visiting and the other basic activities of the public health nurse.
2 In this case what was the nature of the concern of the school? The nurse? Crippled Children's Service? The neighbor? The family? What was being sought from the nurse? What was the nurse seeking from the other agencies?
3 Evaluate carefully the interview conducted jointly by the social worker and the nurse with the mother. Describe what each person was experiencing in relation to maintaining her own self-concept. In this evaluation of the interview take into account all the pertinent concepts pointed up in the Basic Principles of the case. Roleplay this interview applying these same principles.
4 On the basis of the information given in the case how would you explain the various adjustment symptoms presented by Ruth?
5 How could the nurse help Ruth and her mother to take appropriate responsibility for reaching their own solutions?
6 What is known about the somatopsychic aspects of polio in children? How does this knowledge help to understand a situation such as Ruth's?
7 How do the somatopsychic facets of polio relate to what is known about reactions to illness in general?
8 Summarize all the factors that determine how effectively various agencies can serve the same people in the community.

REFERENCES

1 The American Public Health Association, Inc. *Health Supervision of Young Children.* New York, 1955, pp. 80–92.

2 Barker, Roger, *et al. Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability,* rev. ed. (Social Science Research Council, Bulletin 55.) New York, 1953, Chapter III.

3 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 81–149.

4 Ferguson, Marion, and Wayne S. Walborg. "Family Health Service—Opinion versus Facts," *Nursing Outlook,* VI (November, 1958), 640–42.

5 Gurney, Wilma. "Parents of Children with Congenital Amputation," *Children,* V, No. 3 (May–June, 1958), 95–100.

6 Losty, Margaret, *et al.* "A Hospital-to-Home Link for Crippled Children," *Nursing Outlook,* V (November, 1957), 650–52.

7 Reid, Eleanor S. "Helping Parents of Handicapped Children," *Children,* V, No. 1 (January–February, 1958), 15–20.

8 Seidenfeld, Morton A. *Psychological Aspects of Medical Care.* Springfield, Ill.: Charles C. Thomas Company, 1949.

9 Towle, Charlotte. *Common Human Needs.* New York: National Association of Social Workers, 1952, pp. 71–80.

10 Upham, Frances. *A Dynamic Approach to Illness.* New York: Family Service Association of America, 1949, pp. 15–25, 43–85, 168–82.

11 Wallace, Helen. "Progress and Problems in Maternal and Child Health," *Nursing Outlook,* VI (May, 1958), 278–81.

12 Wolff, Ilse. "Interviewing in Public Health Nursing," Parts I and II, *Nursing Outlook,* VI (May, 1958), 267–69; and (June, 1958), 320–22.

DISCUSSION AIDS

Films:

"Development of Individual Differences," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 20 minutes.

The film portrays individual differences as well as similarities seen in family members. It illustrates possible environmental influences on the development of these likenesses and differences. Individual differences in behavior patterns of families are compared. The film encourages an understanding and accepting attitude toward these individual differences in order that each person may develop to his greatest potential.

"Over-Dependency." For a description of this film, see Chapter VIII.

"A Long Time to Grow, Part III, Society of Children—Six-, Seven-, and Eight-Year Olds." For a description of this film, see Chapter VI.

"Sibling Relations and Personality," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 22 minutes.

In a series of case examples, this film demonstrates the significance of relationships a child has with his brothers and sisters throughout developmental years. These relationships are an important factor in personality shaping. Emphasis is placed on the importance of understanding

these influences in helping youngsters through childhood and adolescence.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Karen Green Episode." See Chapter VIII for a description.

X

Challenges to Professional Service—Effects of Behavioral Science and Cultural Change

CASE OF MR. K.

The patient is thirty-seven years of age, married and the father of three girls ranging in age from five to ten years. He is the second oldest in a family of seven children.

The patient used to be a farmer, but since moving to town he has been doing carpentry. Mr. K. sold his share of the farm and bought a house and lot near the outskirts of town. To this new property he has added a garage and a woodshed which he helped to build. The house is furnished adequately and is kept clean and in good condition. The family's savings had been used before Mr. K.'s admission to the sanatorium. The mother now receives a mother's pension because the head of the family will be hospitalized for a long time. Two of their three children attend the parochial school in town, which is within walking distance.

Both Mr. K. and his wife are strong Catholics, and the church seems to be their only outlet outside the home.

There are very few Polish families in their new neighborhood so they have few friends. Mrs. K. has an inferiority complex about being Polish.

Referral.—The case was brought to the public health nurse's attention through the report sent by the mobile X ray unit. The report received on April 7, 1949, presented the following specific problem: to get Mr. K. to go to his family doctor and have a large chest X ray taken. The diagnosis, active pulmonary tuberculosis, was made through the large X ray. The nurse was charged with the responsibility of getting Mr. K. admitted to the sanatorium for care.

Mr. K. was first seen at his farm home on a spring morning. All the family were present in the kitchen where the nurse was asked to take a chair. Mr. K. was polite but curious to know why he was being visited. He is a person of medium height and quite thin. He does all the talking and only occasionally does his wife say anything. The three children are quiet and stick quite close to their mother.

The nurse's attitude was to try to convince this man of the importance of sanatorium care for tuberculosis. She knew she would have to proceed cautiously and watch her choice of words. Mr. K. could not be hurried for fear of antagonizing him and then he would probably do just the opposite of what was wanted. Mr. K.'s father was a very stubborn man, and the nurse was afraid Mr. K. would be just like him. Therefore, all she hoped to do was to gain a ready entrance into the home.

During the first visit the complete family history was obtained. Mr. K. gave the information readily and did not mind having the nurse write it down. Also she explained the purpose of her coming and answered questions. He seemed to be fairly agreeable. He stated then that he did not want to go to any sanatorium.

NURSE. Good morning. I'm the county nurse. I was here about a week ago.

MRS. K. Come in. Mr. K. will be here right away. He's getting ready to go and get his electric treatments.

NURSE. How far does he have to drive?

MRS. K. It's about forty miles. Sometimes he gets someone to go with him.

MR. K. Hello, Nurse. These treatments I get now help me a lot. This man says in eight months he'll cure me. Already I'm 5 per cent better. Then maybe I won't have to go to the sanatorium.

NURSE. I think it would be better for you and for your family if you'd go to the san. There you'd be sure to get plenty of rest. And when you cough you must be sure to cover your mouth and use paper tissues which can be burned. You've got to protect your family this way so they won't catch it from you. The dishes you eat out of should be kept separate from the other dishes and should be boiled after being used. And your clothes, too, must be boiled so as to disinfect them. All this is hard to do at home, but for your family's safety it should be done.

MR. K. We try to do all those things. I'm going to have another X ray taken so we can see how I'm getting along. But these treatments are helping me a lot. I have to start out now.

NURSE. I'll see you again soon. I'll wait until after you have your X ray taken. Good-by.

Being a farmer, Mr. K. had to work long and hard and could not get adequate rest. His family of three girls also put a strain on his run-down condition. Already he was pale and thin and seemed to be underweight. He had no hired man and so had to do everything on the farm by himself. Additional strain came from the long, severe winters and bad road conditions.

The family stayed home most of the time. They had few friends. They exchanged visits with relatives and attended only church functions. Mr. K.'s youngest brother at this time was in a hospital with a diagnosis of tuberculosis. Mr. K. hated to think that he too would have tuberculosis. This caused him to worry a great deal and he did not want to leave his family. He had only a few relatives left in this part of the country, and it was hard to make ends meet.

Remedial Summary.—The nurse suggested his having the first large chest X ray which confirmed the diagnosis of tuberculosis. Instruction was given to the family as to care in the home. Patch tests were given to the children, and they were also brought in for chest X rays. Mr. K. should be convinced that the electric therapist was doing him harm and that he was paying good money for nothing. He should be convinced of his danger to the members of his family. An appointment was made for him to attend the outpatient clinic, to have another X ray taken, and to have a talk with the medical director. This visit, made in September, finally convinced Mr. K. of his need for sanatorium care. So on the twenty-eighth of September he was admitted to the sanatorium. The nurse told the family about aid to dependent children, so they went to the Department of Public Welfare and made their own arrangements.

Over-all Evaluation by the Nurse of Her Procedures.—Proceed cautiously and make full, simple explanations to the family. Learn the patient's attitude toward the disease and help allay any fears regarding it. Explain the nature of tuberculosis and its treatment. Explain how tuberculosis spreads and methods to protect the rest of the family from infection. Teach the importance of seeking good medical advice and following it.

If the nurse's efforts are successful the patient will accept the disease and its treatment more readily, and he will ultimately be able to resume normal living. When the

patient is cured and understands the disease well enough to assume responsibility himself, then both patient and nurse will have accomplished a great deal.

Unsolved Problems.—There is a real need for more education of the general public so that they are made aware of the quacks who are getting to innocent people, promising them quick cures. They must be warned of the fake methods of so-called treatment such as the use of bogus electrical equipment.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF MR. K.

Dramatic Changes in Public Health.—One of the earliest recognized and defined responsibilities of public health workers was the protection of the public through programs for control of communicable diseases. Traditionally, communicable-disease control was based on a unilateral, authoritarian management of cases and community through the use of police power and various enforcement procedures. Major focus was on the disease rather than on the persons who happened to have the disease or were threatened by it. Control of communicable diseases has been made much more effective through developments in chemistry, medical science, casefinding, and various diagnostic and treatment procedures. The public health worker is thus gradually being freed to concentrate time, energy, and interest on working broadly with the person rather than narrowly with the disease.

Need for Alignment between Medical Advances and Behavioral Sciences.—This shift in emphasis affecting public health work has been reinforced by parallel progress in scientific knowledge of behavior. With the freedom to pay more attention to the person has come the increased means of understanding the reasons for people's reactions to disease and to their living experience in general. The be-

havioral sciences—psychiatry, psychology, social work, sociology, anthropology—are making a real contribution in this regard. They are opening up a whole new view of human beings, their growth and development, their relationships with one another, and the dynamics of their adjustment. However, the behavioral sciences also pose new and complex challenges, since the application of these principles and insights often requires considerable change in point of view, technique, procedures, and even programs.

In recent times, on the one hand, there has developed a fantastically effective array of mechanical solutions to people's illnesses, such as the wonder drugs. On the other hand, there has been an equally vigorous development of painstakingly individualized procedures concerned with people's feelings and reactions—just the antithesis of standardized mechanical methods. Paradoxically, the more plentiful and efficient the mechanical solutions of medicine, the greater seems to be the need of patients for the more humanized and individualized approaches.

Challenge Inherent in Recognizing People's Right to Their Feelings.—It is increasingly recognized that the facts of one's life experiences always have unique and individual meanings to each person. These are variations within the framework of common human reactions. The individual's feelings and attitudes may be more important than the events themselves. These reactions are particularly significant since they will have some continuing influence on the future adjustment of the individual. His capacity to be logical and reasonable in his behavior will depend mainly on his feelings.

In our culture many practices and values have been deeply rooted in the assumption that reasonableness is attained by denying, detaching, or minimizing feeling reactions. It is now understood, on the contrary, that to be

logical and reasonable in one's behavior on a healthy basis a person must face, understand, and effectively deal with his feelings. In their emphasis on feelings and emotional reactions the behavioral sciences have brought about a heightened respect for the right of all human beings to have their own ways of reacting to life situations and to work out their own solutions. People in the service professions are faced with the challenge of respecting these rights while still safeguarding social purposes.

The view and feelings an individual has about his own situation may not agree with what others see as urgent or practical for him. Sometimes the need of the professional worker, who is anxious to be helpful and to secure immediate results, may conflict with the patient's need to come to grips with what his illness means in his current life situation. Society demands, and has the right to expect, protection from communicable diseases. The individual often acknowledges this as he thinks about it. This conclusion is not enough, however. He usually needs some time, or at least an opportunity to resolve for himself the struggle between personal self-protective feelings and his feelings of concern and responsibility toward other people. Professional goals or procedures that fail to take into account the individual emotional meanings of human experience will often be futile. This is why a patient frequently feels compelled to set himself in opposition to professional advice and suggestions which are based on purely "logical" analysis.

Problems in Democratization of Professional Service.— There sometimes is a clash between trying to get things done and doing them in such a way that they contribute to the patient's adaptive capacity, that is, so that he can participate in making decisions and plans that are sound and help him to mature. Arbitrary authority, so often used in

the past by professional workers in their relationship with clients or patients, is being reshaped to a more democratic method. This keeps the patient free to accept, reject, or use some of the help offered. Although the process of democratization is an individual matter between each patient and each practitioner, it also is involved with slow and yet far-reaching changes in cultural values. Adjustment to this dual change is paradoxically becoming more difficult. On the one hand, the client is increasing his freedom to question the authority of the professional worker. The latter, on the other hand, is constantly gaining in refinement of specialization which makes his knowledge and skills more authoritative than ever before. The major implication is that giving professional advice, information, or skilled service cannot be an end in itself. Rather, the professional person and the client have an increased responsibility to achieve a relationship of mutual respect and confidence. This will enable the client to make effective use of the service without violation of his basic needs, self-interest, or autonomy.

SOME QUESTIONS FOR DISCUSSION

1 How do you account for the changes in Mr. K.'s attitude toward admission to the sanatorium? How are attitudes usually changed?
2 What do you think the diagnosis of tuberculosis meant to Mr. K. as a person? As the head of a family? To the other family members? To the nurse?
3 What is your impression of Mr. K. as a person? On what do you base your view?
4 What does enforced or prolonged separation from one's family mean to a person? To other members of the family? To the community? How does this apply to Mr. K. and his family?

5 Comment on the nurse's over-all evaluation as presented in the last two paragraphs of the case.

6 With reference to several acute and chronic diseases with which you are most familiar, (*a*) describe common denominators in patients' feelings and reactions, and (*b*) describe feelings and reactions that may be unique to a specific disease. Relate to your answers for (*a*) and (*b*) the principle of individual differences in response to life situations.

7 What are some of the criteria for successful work with patients who have communicable disease? Chronic disease conditions? Discuss the variations in criteria used by different agencies.

8 Discuss some basic principles from the behavioral sciences that could guide the interpretation of a communicable disease control program in a community. Describe the influence of such concepts on any community program you have known.

9 In light of your own observation or experiences, comment on the problems in democratization of professional service presented in the Basic Principles of this case.

10 Describe reactions of (*a*) workers, (*b*) patients, and (*c*) families to communicable disease in relation to differences in age of patients, i.e., children as compared with adults.

REFERENCES

1 Alfano, Genrose J. "What Rapport Means to Me," *Nursing Outlook,* III (June, 1955), 326–27.

2 Barker, Roger, *et al. Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability,* rev. ed. (Social Science Research Council, Bulletin 55.) New York, 1953, Chapter IV.

3 Caseley, Donald. "Trends in Medical Practice—Their Implications for Nursing," *Nursing Outlook,* V (May, 1957), 300–302.
4 Gilbert, Ruth. *The Public Health Nurse and Her Patient,* 2nd ed. Cambridge: Harvard University Press for the Commonwealth Fund, 1951, pp. 197–200, 210–22, 230–44.
5 Ginsburg, Ethel. *Public Health Is People.* New York: Commonwealth Fund, 1950.
6 Mead, Margaret. "Understanding Cultural Patterns," *Nursing Outlook,* IV (May, 1956), 260–62.
7 Rieman, Dwight W. "Working with Tuberculosis Patients," *Nursing Outlook,* III (July, 1955), 394–97.
8 Sanford, Fillmore H. "Creative Health and the Principle of Habeas Mentem," *American Journal of Public Health,* XLVI (February, 1956), 139–48.
9 Schmahl, Jane A., and Jeanette F. Plutnicki. "The Teacher in the Making," *Nursing Outlook,* III (April, 1955), 201–2.
10 Upham, Frances. *A Dynamic Approach to Illness.* New York: Family Service Association of America, 1949, pp. 7–54, 85–128, 168–91.
11 Witmer, Helen L. (ed.). *Teaching Psychotherapeutic Medicine.* New York: Commonwealth Fund, 1947.

DISCUSSION AIDS

Films:

"Working for Better Public Health through Recognition of Feelings." For a description of this film, see Chapter IV.
"Broken Appointment." For a description of this film, see Chapter IV.
"Unconscious Motivation," Associate Films, Inc., 79 Adams Street, Chicago 3, Illinois. 38 minutes.

This film demonstrates how our everyday thoughts, feelings, attitudes, and actions may be influenced by situations previously experienced. It illustrates how behavior is not always rational and under conscious control and how anxiety may block learning and influence interpersonal relationships.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Mr. Stone Episode," Educational Aids, Brooklyn, N.Y.

Part I: A student nurse shows acceptance of an abusive and demanding patient who has a coronary occlusion.

Part II: The same student nurse discusses her reactions to the patient with the supervisor.

Part III: The nurse returns to the patient and helps him accept his dependence.

XI

The Patient as a Person—A Holistic View

CASE OF MRS. SMITH

Mrs. Smith, age forty-three, is employed in a medium-sized commercial establishment. Her husband works in a large brewery in a fairly well paying job. Mr. and Mrs. Smith have no children.

The first contact with Mrs. Smith was at the time she came to the Employee Health Service for a pre-employment health interview, January, 1957.[1]

At the time the nurse interviewed Mrs. Smith, she talked freely about her health and was very pleasant. She was an attractive, well-groomed woman in her early forties. She was Irish and seemed to have a good sense of humor. She had not been employed outside of the home for a long time. During

[1] The establishment does not have a complete physical-examination program, but prospective employees are interviewed by the nurse. A complete health history is taken and routine tests are made, including vision, blood pressure, and urinalysis. In addition, each applicant is sent to a local hospital for a chest X ray. There is a part-time medical director who visits the health service periodically to review the health interview findings and provide consultation and guidance on the employee health program.

the health interview, Mrs. Smith explained that she was primarily interested in working in order to keep busy. She said she was extremely tense and nervous and had lost about ten pounds as a result of the terrific shock of her father's death. He died suddenly from a heart attack about three months before at the age of seventy-one. She stated that she had been under the care of a doctor but did not feel he had helped her. He kept her coming back for shots which were very expensive and did not seem to do any good. Mrs. Smith stated she had gone through menopause with no unusual complications. She had had several complete physicals including an EKG, chest X ray, and a basal metabolism rate, all of which she stated were normal. In addition, all of the tests given to her in this department were normal. Mrs. Smith was employed as a file clerk.

January to April, 1957.—Mrs. Smith came into the Employee Health Service Department a few times complaining of indigestion and headache. These seemed to be minor and were relieved with simple medication. She appeared to be getting along fine on her new job.

May 16, 1957.—Mrs. Smith came into the health service about 8:30 A.M. She was visibly nervous and agitated and said, "Something is wrong with my hand. I think I've had a stroke."

NURSE. What makes you say that?

EMPLOYEE. I suppose I shouldn't say that, but my hand and arm are dead. I can't use them. My hand is so weak.

NURSE. Sit down here beside my desk so I can check you over a bit. Have you ever had a stroke?

EMPLOYEE. No, but I can't use my hand.

NURSE. Have you ever been told that you have high blood pressure?

EMPLOYEE. No, but my hand feels so funny—not like when it goes to sleep, just dead and funny. I tried to write

a note to my husband this morning and I couldn't write.

NURSE. Can you pick up this pencil?

EMPLOYEE. Yes, I can, but I can't write.

NURSE. Here's a piece of paper. See if you can write.

EMPLOYEE. Yes, I can write my name now, but I couldn't at home, and my hand feels funny.

NURSE. Your pulse is fine and your blood pressure seems to be all right. It is the same as when you were hired a few months ago. Have you been doing anything different at work or at home that might have caused this?

EMPLOYEE. No, I haven't been doing anything different.

NURSE. Have you been doing any housecleaning or any gardening that might have overtired your arm?

EMPLOYEE. No, but I did write four letters night before last. Usually I type my letters, but this time I wrote them.

NURSE. Were they long letters?

EMPLOYEE. One of them was three pages on both sides, but the others weren't so long.

NURSE. Does your hand ever go to sleep after you have done a lot of work with it?

EMPLOYEE. No, but I've been having this pain in my chest, too, you know; I told you about it when I had my interview. I've had that almost all the time since my father died in October. That was such a shock to me. I lost all that weight and had to go to the doctor and now this, and I think it is all from the terrible shock.

NURSE. What did your doctor say about the pain in your chest?

EMPLOYEE. He said it was just nerves, nothing wrong, and I should get a job and go to work and forget about it.

NURSE. Did he give you any medicine to take?

EMPLOYEE. No, he said the tests didn't show anything wrong and I didn't need any medicine. He said I should stop worrying.

NURSE. I think our doctor will be in this morning. We'll

have you lie down awhile, and let him check you over when he comes in. Then we can decide whether you should try to work today or whether you should go home and see your doctor.

The Medical Director did not come in, but after resting awhile, the employee wanted to go to work and promised to come back in to see the nurse at noon.

The employee did not return, but when questioned whether the employee seemed able to do her work, the supervisor reported to the nurse that the employee had told everyone in her department that she thought she had had a stroke. The employee had also asked to leave work early so that she could go to her doctor but had remained at work until quitting time. The nurse called the employee in, called her doctor for her, and made an appointment for her to see the doctor at six o'clock. This was done because the nurse felt the employee needed reassurance that she was physically all right.

May 17, 1957.—The employee came in to see the nurse, and the following interview transpired.

EMPLOYEE. I'm so mad at the doctor. All he did last night was take X rays of my hand and wrist. It'll cost me twenty dollars for the X rays, and he didn't do anything for me at all. What did he need X rays for? He can't tell anything from them, can he?

NURSE. Yes, there are things that a doctor can tell from X rays. For example, he can tell whether you might have arthritis or some other condition in your wrist that is causing the weakness in your hand. What else did the doctor do for you?

EMPLOYEE. He didn't do anything else. All he did was take X rays, and it'll cost me twenty dollars for them and I still won't know anything.

NURSE. Did he listen to your heart or take your blood pressure?

EMPLOYEE. No, he didn't do anything like that. That's why I quit going to him this winter, too. He was giving me shots all the time and they didn't do me any good.

NURSE. What kind of shots was he giving you, do you know?

EMPLOYEE. No, all I know is that it cost me seventy-five dollars, and he didn't do me any good. I still was nervous and I had that pain in my chest.

NURSE. Is there some reason why you are nervous about your father's death at this time? Didn't you say he died in October? Was he living with you at the time?

EMPLOYEE. No, he wasn't living with me. But he died of a heart attack, and it was so sudden and such a shock to me. That's two deaths in my family in less than two years and they've both been such a shock to me.

NURSE. Who was the other member of your family who died?

EMPLOYEE. My sister—it'll be two years June fourth. I was in bed with her when she was dying and I didn't know it. If I only could have done something to help her. I called the doctor and he wouldn't come out to see her. He said there was nothing wrong with her. And then she was choking and couldn't get her breath, and I called the rescue squad and they called the ambulance. I called her husband to come home from work, but he didn't get there till the ambulance had left. And she kept pleading with me to go to the hospital with her; but I said, "Betty, I can't. I can't leave the children alone." The children were sleeping upstairs and I didn't wake them up. And then her husband came home just after the ambulance went around the corner. Oh, if I could only have done something for her, or if the doctor had only come out!

NURSE. Had she been under the care of the doctor that you called?

EMPLOYEE. Yes, for quite a while, and he had said he was going to straighten her out. See, my mother died when I was nineteen and I brought up my sister and brothers. I was like a mother to her. She got married when she was nineteen, and she had three children. But she was under the care of a doctor for a long time for a heart condition. But she didn't seem to be getting along very well, and I had heard about this doctor so I said to her why didn't she go and she did. And he said she didn't have a heart condition, or anything wrong with her, and that he would straighten her out. But she couldn't go out much, and her husband was working nights, so that's why I was staying with her —so she wouldn't be alone. And then I was in bed with her when she was dying, and I didn't do anything for her.

NURSE. But you did call the doctor and you called the rescue squad. When did she die?

EMPLOYEE. She died before she got to the hospital.

NURSE. Did they do an autopsy? What did they say caused her death?

EMPLOYEE. Yes, she died of a hemorrhage of the spleen. It wasn't from her heart.

NURSE. Did you ever talk to the doctor about the cause of your sister's death?

EMPLOYEE. Yes, not to the one I'm going to now, but to another doctor; and he told me I should stop blaming myself, that nothing would have made any difference or could have been done for her. But I still think her doctor should have come out when I called him that night. I still blame him, and I said to him afterwards, "Aren't you ashamed that you didn't come when I called you?"

NURSE. What did he say when you asked him that?

EMPLOYEE. He just shrugged it off and said she didn't

need him, that she would have died anyway. That's why I can't get over all of this shock. You'd feel the same way if this happened to you, wouldn't you?

NURSE. Yes. I think probably I would. I don't know really how I would feel because I've never been faced with such a situation.

EMPLOYEE. That's why I keep thinking about it and thinking about it. I can't get it out of my mind. I know I should, but I can't. I have to go back to work now. I came in here on my coffee break; I didn't want coffee anyway.

NURSE. Are you going to see the doctor again? Did he tell you to come back?

EMPLOYEE. Yes, I'm supposed to see him tonight.

NURSE. Let me know what he says.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF MRS. SMITH

Life and Job Adjustment—a Continuum.—This case concerns an employee in an industrial setting who comes to the nurse with problems that interfere with job performance. The occupational health nurse often works with employees who present symptoms that reflect the close intertwinings of physical and emotional discomforts. Through this symptomatic expression of problems in the work setting, questions are raised regarding the relationship between these difficulties and the employee's other life situations.

At work, just as in all other facets of daily living, there are continuous demands on each person's emotional maturity, his skills and capabilities. On the job there is a double demand. There is an external pressure to put in the required hours and to produce in adequate quantity and quality. There is also an internal pressure arising from the need to feel that one's workaday efforts are worth while. In addition, this need requires that one feel personally adequate

in self-comparisons with others. There is a strong mutual influence between basic feelings and attitudes on the job and the nature of the individual's general adjustment elsewhere.

Unique Helping Role of Occupational Health Nurse.— One of the basic functions of the occupational health nurse is to promote and help maintain the health and safety of employees. The nurse's favorable liaison relationship between management and employees enables the latter to seek her out for relief and support when they are burdened with symptomatic difficulties. With her they do not usually risk any serious threat to their normal and necessary emotional defenses. The nurse can often perform this supporting role within the framework of the policies and procedures set up for the legal protection of management, nurse, and employee. With the great improvement in the mechanical aspects of industrial safety, the nurse is able to shift job emphasis more and more to health education and interpersonal relationships as they apply to the health and safety of employees.

The occupational health nurse is usually quite accessible to workers; traditionally she has been looked to as a source of help and support and is trusted to respect confidences. Seeking her out for help does not generally carry social disapproval among co-workers. For these reasons she is in a unique position to help people, provided she understands behavior and interpersonal relationships and can make constructive use of herself in the helping role. Because of the large numbers of persons and the variety of problems they bring to her, the occupational health nurse has special need to know how to work with various community resources and how to make appropriate referrals to them. Potentially she has a vital role to play in preventive health since she has

an unusually good relationship with, and broad access to, mothers and fathers of young children.

Helping to Strengthen Adaptive Capacity.—Earlier in this book it was pointed out that the problems of individuals are tied causatively to their past. This causation may not always be very clear or obvious in the current situation, nor is it always necessary for the professional worker to search for historical causes. It is very important, however, to be aware that causative factors are always operating.

The professional person may feel limited or unsure in understanding the current situation if he feels he has too little information about the specific causative factors. He can, however, be of help if he understands the universal principles of how people develop, learn, and adjust and if he is sensitive to and supportive of the needs, feelings, and attitudes of the person being helped. This professional understanding and support enable the individual to develop insight into himself based on a conscious awareness of self as a whole person with many interconnected facets. Through better perception of himself as a whole, understandable being, he is more able to arrive at his own appropriate solutions.

Perhaps more important than the help given in solving immediate problems is the fact that this enabling process tends to strengthen the person's general capacity to adapt to whatever he has to face in life.

SOME QUESTIONS FOR DISCUSSION

1 Describe the influence of various health settings as they affect nurse-patient relationships: hospital, health department, industry, school. What are the similarities? Differences?
2 What would help the nurse in understanding Mrs.

Smith's problems? What are some of the ways in which the nurse can determine the possibilities and limitations of her role? How well does the nurse understand Mrs. Smith's needs? What are the clues on which you base your impressions?

3 What might be an ideal picture of community resources in relation to occupational health nursing services? What kind of agencies would be available? What type of referral procedures would be used? Recognizing that there are few such utopian situations, what kind of agencies can the occupational health nurse usually expect to find, and what type of referral procedures can be used? Compare the discussion of the above with the situation in your own setting.

4 Discuss the interview of May 16. Relate it to principles brought out in Garrett's *Interviewing: Its Principles and Methods* and in the film, "Working for Better Public Health through Recognition of Feelings."

5 What is meant by dealing with the "whole person" and the "whole situation," that is, "the holistic approach"?

6 What is meant by the term "self-concept"? What effect does the self-concept have on behavior? How is this illustrated in this case with reference to Mrs. Smith? With reference to the nurse?

7 Speculate on some of the possible experiences and relationships which Mrs. Smith may have had in childhood. Discuss the method of speculation as an aid in understanding people. What are some of the safeguards to use in speculation?

8 How do nurses and other professional people decide what is unreasonable behavior in a patient? How may they feel in response to such behavior?

9 How do the needs and feelings of the nurse and the patient influence each other? Discuss how such inter-

action may affect the patient's ability to assume responsibility for his own problem solving. How is this reflected in the Case of Mrs. Smith? In the Case of Jerry?

10 Interpret the dynamics of Mrs. Smith's specific symptoms.

11 Discuss the three-way communication problem (doctor-patient-nurse) as illustrated in this case.

REFERENCES

1 Abramovitz, A. B. "The Industrial Nurse and Interpersonal Relationships," *Nursing World,* CXXIV, No. 7 (July, 1950), 329, 330, 333. (Available in mimeographed form.)

2 Bojar, Samuel. "The Psychotherapeutic Functions of the General Hospital Nurse," *Nursing Outlook,* VI (March, 1958), 151–53.

3 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 81–107.

4 Cameron, Norman, and Ann Magaret. *Behavior Pathology.* Boston: Houghton Mifflin Company, 1951, pp. 369–72.

5 *Emotions and Physical Health.* New York: Metropolitan Life Insurance Company, 1954.

6 Felton, Jean Spencer. "Nursing in Industry," *Nursing Outlook,* I (April, 1953), 222–24.

7 Garrett, Annette. *Interviewing: Its Principles and Methods.* New York: Family Service Association of America, 1958, pp. 7–59.

8 Grinker, Roy, and Fred Robbins. *Psychosomatic Casebook.* Philadelphia: Blakiston Company, 1954.

9 Kaplan, Stanley, and Helen Plogsted. "The Nurse and Psychosomatic Medicine," *Nursing Outlook,* V (April, 1957), 207–9.

10 Parker, Cherry. "The Interview in Industrial Nursing," *Nursing Outlook,* VI (June, 1958), 345–47.

11 Witmer, Helen L. (ed.). *Teaching Psychotherapeutic Medicine.* New York: Commonwealth Fund, 1947.

DISCUSSION AIDS

Films:

"Over-Dependency." For a description of this film, see Chapter VIII.

"The Feeling of Rejection," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd Street, New York 18, N.Y. 30 minutes.

An interesting and realistic portrayal of a young woman whose symptoms of emotional disturbances are in the form of physical complaints. The causative factors in childhood relationships are pointed out clearly. The three important themes shown are the following: (1) Emotional difficulties have traceable causes. (2) Stable relationship with loving, understanding parents is basic in preventing emotional problems. (3) Even well-intentioned parents may unwittingly create difficulties in their children.

"Unconscious Motivation." For a description of this film, see Chapter X.

XII

Family-centered Service— Opportunities and Limitations

CASE OF MRS. THOMAS

Mrs. Thomas is an attractive woman about thirty-eight or forty years old. She is the mother of four girls ranging from three to nine years of age. The nurse does not know much of the family background except that Mrs. Thomas' father was a minister in a college town. Mrs. Thomas is a university graduate and has had voice culture. Before her marriage she was a high-school teacher. Mr. Thomas is a university graduate. He has held executive positions in schools but at present is a salesman. The Thomases own their home which is an attractive, comfortable place with nice outdoor surroundings, including a pleasant garden spot which Mrs. Thomas enjoys working.

The nurse has had direct contact with Mrs. Thomas at child health centers and immunization centers. She seemed then like a normal, happy mother, perhaps a bit too concerned about the children but not more so than many young

mothers. The next contact was made in the home about four years ago regarding a school problem.

Mrs. Thomas joined in the conversation from the kitchen but did not get in line with the nurse's vision. Later, Mr. Thomas told the nurse that this withdrawing behavior had been going on for some time. He stated that they had both been members of the choir, but after the baby came they could not always get a babysitter. Many times they took turns in going to choir practice. If he should be told that he had sung nicely, Mrs. Thomas would take exception to it and be quite hurt. Finally, she dropped out of the choir as she felt Mr. Thomas was more popular than she was. Then she refused to answer the door, which she continues to do, and also gave up doing the shopping. She did not go shopping at all in the village. Occasionally she went to a nearby city to shop.

The husband and the family doctor tried to talk with Mrs. Thomas to get her to have a physical checkup, but she refused. Mr. Thomas then tried to have the doctor call at her father's home as if just dropping in for a visit when Mrs. Thomas was there, but she refused to talk with the doctor.

Because his work with schools kept him out of the home in the evenings, Mr. Thomas finally gave it up and bought a garage. However, this did not prove satisfactory, either. So now he does work that keeps him away from home quite a bit, as nothing he does is right and home life has become a trial.

The husband has talked to the nurse about how to handle his wife. Mrs. Thomas is quite abusive of him with her tongue. When the youngest child was about six months old, one of Mrs. Thomas' relatives died. He took his wife to the funeral, but he did not go in to talk with the relatives because she had told them such wild tales about him. He

didn't know whether they knew of her condition. If not, they certainly wouldn't welcome him, so he used the baby as an excuse to stay in the car.

The local doctor talked with the nurse in regard to Mrs. Thomas. He tried in various ways to help her but was unable to. Finally, the doctor talked quite sternly to her, so now she states, "I will talk over nothing with him." The neighbors are quite concerned about the children, whether or not they are properly fed and whether it is safe for them to be there with the mother. The children do the shopping and also make the outside contacts for the family which, no doubt, makes them feel the difference between their mother and the other mothers.

The nurse stopped at the home to tell the mother that the oldest daughter was having some difficulty with her vision, but she was not admitted. About six weeks later, the nurse called at about ten o'clock in the morning. After she had knocked several times the oldest child came to the window and said she could not open the door. The nurse asked, "You know who I am, don't you?" The child said, "Yes." The nurse asked the child about her vision. Then she asked to talk with the child's mother or father. The father was not at home, but the girl called her mother. She called several times and finally told the nurse that her mother was in the garden. The nurse asked if she might go to the garden to talk with the mother. The child went to see. The mother told the child that the nurse could come to the garden. So she did and as she walked across the back yard remarked that it was an attractive place in which to work and play. Mrs. Thomas commented, "We used to enjoy it." The nurse explained she had stopped at the house previously but that no one was at home. Mrs. Thomas quickly stated, "Oh, yes, I was at home. I didn't answer the door. I don't always answer it." The nurse told her about the oldest daughter's

vision and indicated that the other youngster should have her vision tested, also. She observed that the younger child had a slight strabismus on the left and advised having the eyes examined before school started.

Mrs. Thomas took the opportunity of talking over different health problems with the nurse such as eating habits of the children, causes of constipation, and posture. One of the girls had a very definite droop to one of her shoulders. The nurse spoke about this and suggested that the mother see a doctor regarding exercises. Mrs. Thomas wanted the nurse to tell her what exercises would help. The nurse replied she would be unable to do that but would talk with the doctor about it and ask him about having the physical-therapy consultant call. Mrs. Thomas stated that the doctor had taken X rays, but she didn't know of what.

Later, when the nurse talked with the doctor, he clarified that the child had complained of pain through her left chest; and the X rays revealed she had had two fractured ribs that were now entirely healed. The nurse asked about the physical-therapy consultant going in. The doctor said by all means to have the consultant call there, not only for exercises for the child, but also for the contact with the mother.

A couple of times while talking to the nurse the mother spoke of being queer, or rather, that people thought she was queer. The first time the nurse did not hear the word. But the second time Mrs. Thomas said it, the nurse asked, "Who says you're queer?" The mother quickly changed the subject and did not again refer to it.

Mrs. Thomas seemed to enjoy the visit with the nurse and asked about the home calls she was making. The nurse, to make Mrs. Thomas feel that this was routine and that the call to the Thomas home was a part of it, stated she had several calls to make. Mrs. Thomas apologized, "I am keeping you," turned and hurriedly went to the garden.

The nurse reassured her, "Oh, no, you aren't, I have plenty of time," but Mrs. Thomas kept on going. The nurse said, "I will see you soon." Mrs. Thomas responded over her shoulder, "All right."

One of the neighbors, who had seen her at the Thomas home, happened to meet the nurse downtown and said, "This is just plain curiosity, but I saw you at our next-door neighbor's and wondered how you were treated?" The nurse replied that she had a nice visit and Mrs. Thomas was very pleasant. The neighbor remarked that it was seldom that way and the neighbors did not have any contact with Mrs. Thomas as she refused any advances they made, sometimes in a very huffy manner.

The nurse made a home call to inquire if the children had been to the doctor regarding vision. The two youngest children were sitting on the porch with two little neighbor children. The nurse asked if their mother was at home. The older child said she was and for the nurse to go to the back door as the front door was not used; it was kept locked. The nurse went to the back door. The children went with her and the older child called to her mother. The mother answered, "Yes?" and the nurse said, "I think she is in the basement." The mother replied that she was sitting at her bedroom window. The little child said, "The nurse is here to see you." Mrs. Thomas came out promptly and invited the nurse into the house.

The nurse said that she had come to inquire about the children's vision. The mother puzzled, "I didn't know you were coming back." The nurse asked, "Don't you remember we talked about doing exercises? I was to talk to the doctor about having the physical-therapy consultant call to show you and the child how to do them." Mrs. Thomas replied, "Yes, I remember now, but I didn't think that is necessary as the child is not crippled, and I don't see any reason for

having her do exercises." The nurse explained how doing exercises now would help the child develop correct posture and she would be better physically. The mother commented, "Well, I think it would help her more than physically as she is getting quite sensitive about her shoulder." The nurse asked if Mrs. Thomas didn't think that would be sufficient reason for the child doing the exercises. Mrs. Thomas agreed it would.

The nurse turned the conversation back to the children's vision. Mrs. Thomas said the children had been taken to the clinic, and the doctors thought that neither one of the girls needed glasses. Mrs. Thomas didn't quite agree as the second oldest child had quite a lot of irritation in her eyes and frequently had pus in the corners of them. The nurse suggested that the child might have a nasal irritation causing the pus.

Mrs. Thomas observed that the child had a loud, coarse voice. At one time she thought the child's hearing was the cause of it, but the hearing had been checked and it was all right. Mrs. Thomas thinks the child must have some infection in her throat. Her voice distresses the mother a great deal. Also, this child is a bed wetter and has to urinate frequently. The nurse asked if Mrs. Thomas had had the doctor examine the child or the urine to see if there was any infection which might be causing the trouble. Mrs. Thomas asked about having a urinalysis done, and the nurse stated that it could be done at the doctor's office. The nurse told Mrs. Thomas that when she talked to the doctor she should explain that the child was nervous and to tell him anything else that might pertain to her condition. Mrs. Thomas remarked that she wouldn't be talking to the doctor. The nurse said, "Why? Don't you like him?" She liked him all right but she never went out. The nurse queried, "You don't mean that you never go shopping or downtown?" Mrs. Thomas answered, "That is what I mean

—I am a very queer person!" The nurse said, "You look like a normal, happy person to me." Mrs. Thomas answered, "You can't tell everything from the outside."

During the conversation the subject of spastics and subnormal children came up, and this gave the nurse a chance to talk about mental upsets as being illnesses and no different from other illnesses. She mentioned that wonderful things were being done to help these patients. Mrs. Thomas happened to look up and see the children coming down the street and said she had to get lunch ready. During this conversation Mrs. Thomas also mentioned incidentally that she cried easily. She said, "Of course, I had to cry as usual," or something to that effect.

The interest Mrs. Thomas and her husband have in music was brought out when they were talking about the child with a coarse voice. The nurse said, "You are both talented in music. I hope the girls are, too." Mrs. Thomas thought she and her husband could sing well together, that he had a beautiful voice but hers was not good. When the nurse was leaving she said to Mrs. Thomas that she didn't usually visit so long, but she had found the conversation very interesting.

The nurse really doesn't know what would be effective procedure in this case but would like to do something that will help this mother see what she is doing to her children in retiring from the world. The mother was quite open in saying that she is queer and retiring, but if the nurse works too directly on these comments she fears she may lose her contact with Mrs. Thomas.

BASIC PRINCIPLES ILLUSTRATED IN THE CASE OF MRS. THOMAS

Family Focus in Public Health Nursing.—The intended focus of public health nursing service is the family. Limitations in time and in access to the various family members

may often make it difficult to maintain this focus adequately. The intricacy and complexity of relationships within the family group pose further problems for the family-centered nursing service.

Opportunities and Problems in Home Visiting.—Compared with various other professional workers, the public health nurse is able to take more initiative in visiting homes and can have a broader scope of purpose in home visiting. Nor is she limited to a relatively small or specialized clientele. She can serve the community as a whole on an individual family basis and can give considerable attention to health building and prevention rather than to illness and pathology alone. Flexibility and freedom of access to many homes as a professional visitor present the public health nurse with challenging opportunities as well as considerable problems. The natural defensiveness of families has to be met and unexpected facets of family needs, conflicts, and difficulties have to be understood.

The nurse will automatically be engaged in a process of screening and sifting her perceptions of the family from the very first contact in order to set necessary limits in terms of what she can or cannot do. She needs to know what her own function is as well as what other resources may be required. She must also know something of the feelings and attitudes of the patient and the family. It is much less important to know the detailed facts of the family situation than to get some picture of what these facts mean to the people involved.

It is equally important to know what strengths and potential capacities are available within individuals to enable them to work out fairly independent solutions. Supporting emphasis by the nurse on feelings, attitudes, and meanings will usually build a helpful relationship between the family and the nurse. With such a relationship, she will

not feel impelled to make diagnoses or offer manipulative advice or impose answers on them.

Importance of Holistic Approach.—From this case it is apparent that the nurse's sincere interest in the patient and her intent to be supporting can be conveyed even to people who are seriously disturbed. This good feeling can be undone unless it is guided by an understanding of the total behavior and total situation of the patient. To see things as a whole is not easily achieved. It is, thus, understandable that confusion and frustration may often overwhelm the professional worker and the patient when they are trying very hard to deal with one isolated part, or several splintered aspects, of a problem. Practical urgencies often encourage a splintered approach. What seems practical and efficient at the moment will often prove wasteful and self-defeating in the long run.

Sources of Basic Satisfaction in Public Health Nursing.—The desire to ease people's suffering is a major motivation of nurses, but emotional pains are not always readily assuaged. The only one who can really obtain lasting relief is the sufferer himself, usually on a gradual basis. The unreasonableness of the symptomatic difficulty arises from a conflict in feelings and emotions. Reasonableness will be restored mainly when this conflict is resolved and feelings can be expressed more constructively. The fact that the nurse also has feelings makes it important for her to be aware enough of her own reactions so that she can keep them from getting entangled or confused with those of the patient. The ultimate objective and the deepest satisfaction of the public health nurse is to be found in helping to release the patient's potential so that he can resolve his own conflicts and further his own maturation.

SOME QUESTIONS FOR DISCUSSION

1 Why does public health nursing emphasize a family-centered service? Does this emphasis differ from hospital nursing?
2 What does the public health nurse need to know about the sociology of family life?
3 Describe your idea of the kind of training and preparation for home visiting that enables public health nurses to practice this function with satisfaction and skill. Discuss this in relation to the suggestions by Freeman in *Public Health Nursing Practice,* Chapters 6, 7, and 8.
4 Why is it that people with intelligence and education have problems in family living? Do community expectations of such people make a difference in their adjustment?
5 Looking back over the development of problems in this case, were there ways in which effective preventive procedures might have been instituted when the mother came to the child health centers and the immunization clinic? How would such procedures as described in McFadden and Walsh's "The Nurse's Conference in a Child Health Station," and in *Health Supervision of Young Children,* by the American Public Health Association, contribute to this?
6 How can a professional worker know when he is seeing a patient's situation objectively and when he is unduly injecting his own reactions or interpretations into it?
7 As described in the case, interpret the following: (*a*) the doctor's general view of the Thomas family's problems, (*b*) the doctor's idea of his role, (*c*) the neighbor's view of the family's problems.
8 How would the nurse define her limitations in working

with this family? How would her view of her role be altered if she had unlimited resources to which she could turn? What sort of agencies would she call upon? Describe in detail how she would go about making referrals.

9 Discuss the dynamics of Mrs. Thomas' specific symptoms.

10 In providing family service, how can a nurse determine where and how to place the focus, i.e., the children's needs and problems in relation to those of the mother?

REFERENCES

1 The American Public Health Association, Inc. *Health Supervision of Young Children.* New York, 1955, pp. 20–64, 95–99, 122–29.

2 Burton, Genevieve. *Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses.* New York: Springer Publishing Company, Inc., 1958, pp. 169–97.

3 Cameron, Norman, and Ann Magaret. *Behavior Pathology.* Boston: Houghton Mifflin Company, 1951, pp. 230–46.

4 Freeman, Ruth. *Public Health Nursing Practice,* 2nd ed. Philadelphia: W. B. Saunders Company, 1957, pp. 89–162.

5 Hymes, James L., Jr. *A Healthy Personality for Your Child.* U.S. Children's Bureau, Publication No. 337. Washington, D.C.: Government Printing Office, 1952.

6 McFadden, Daisy, and Evelyn Walsh. "The Nurse's Conference in a Child Health Station," *Nursing Outlook,* IV (July, 1956), 392–94.

7 Ridenour, Nina. *Keystones in Psychological Thinking about Young Children.* New York: Child Study Association of America, 1957.

8 Wolf, Anna W. M., and Margaret C. Dawson. *What Makes a Good Home*. New York: Child Study Association of America, 1956.

DISCUSSION AIDS

Films:

"Feelings of Depression," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd St., New York 18, N.Y. 30 minutes.

This film is a case history of a young man in his early thirties. He is a conscientious, hard-working person whose entire life is threatened by his emotional upset. The roots of the difficulty are traced back to his childhood. He typifies the good and well-behaved child whose problems are not recognized early because he causes no difficulty. Prevention is possible in such instances if parents and teachers acquire some understanding of the normal problems of adjustment common to all children.

"Broken Appointment." For a description of this film, see Chapter IV.

"Preface to a Life." For a description of this film, see Chapter IV.

"Face of Youth." For a description of this film, see Chapter V.

"Shyness," McGraw-Hill Book Company, Text and Film Department, 330 West 42nd Street, New York 18, N.Y. 23 minutes.

From depicting the lonely existence of a typically shy adult, the film turns to a study of three children: Anna, shy but wistfully wanting association with others; Jimmy, whose excessive timidity is really a symptom of emotional disturbance; and Robert, aloof but happily inde-

pendent. Teacher, psychiatrist, and parents bring about a change in the children's adjustment.

Audio-teaching Aids:

Patient-Nurse Relationship Records, "Mrs. Davis Episode." See Chapter IV for a description.

XIII

Issues Underlying Role Dilemmas of Professionals

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We live in an era that idealizes change. Extensive technological shifts, population expansion, and alterations in social values encourage experimentation in traditional patterns of behavior. Older knowledge proves insufficient as a basis for contemporary practice in the sciences and in the professions.

As this casebook itself shows, society's expectations concerning public health nurses are in process of becoming redefined. Their activities no longer fit the traditional images of the past.

Professionals often deal with emotionally charged personal problems. Society expects recommendations and actions in difficult situations beyond independent solutions by those most personally concerned.

Both the element of change in work responsibilities and the critical emotional significance of professional behavior

suggest that those who examine the previous cases should consider their full implications with care. As an aid to this, this final chapter consists of the statement of certain of the issues suggested in the material, issues of broad significance for society, for profession, and for professional. It makes explicit certain dilemmas which confront profession and professional and which require choices. The discussion reveals our conviction, shared with Everett Hughes, that ". . . for an understanding of human work one must look at a wide variety of kinds of work and of their social matrices." [1] References to many diverse specialties are therefore included.

CHANGE AND SPECIALIZATION OF KNOWLEDGE

One dilemma results from change itself. The occurrence of change is so well known that we usually take it for granted, but it merits some detailed discussion. The total knowledge shared within society and assigned to work roles rather than to other roles is highly changeable. The knowledge of any particular epoch is very different from that of the past and the future. Our cultural history shows that the over-all amount of specialized knowledge connected with all occupational roles has increased. However, the change is uneven—more rapid in certain work roles, less rapid in others.

In some areas of work, technical knowledge is less than it once was. Some varieties of antique glass, for example, were crafted in manners that we can not now duplicate, despite the investigations of scientists and engineers. When the Industrial Revolution spread throughout Western society, many specialized skills of master artisans fell into dis-

[1] Everett C. Hughes, "The Sociological Study of Work: An Editorial Foreword," *The American Journal of Sociology,* LVII (March, 1952), 424.

use and ultimately could no longer be practiced as before. The large-scale social organization known as the factory proved to be an economically more productive and a socially more efficient division of labor than the guild system. This new pattern of social organization reduced the amount of knowledge possessed generally by men in their individual occupational roles. In time, the semiskilled machine tender has succeeded the master craftsman. He knows less than his predecessor; he adjusts to a machine and does not practice a trade; brief on-the-job training makes familiar the machine operations required and replaces the lengthy apprenticeship previously demanded. The external controls of the machine have replaced the self-controls of the creative artisan.[2]

While the total extent of knowledge has become greater, the individual's knowledge and the personal skill of the many who participate in productive effort have often decreased. These contrary tendencies have gone along with the expansion of the numbers of persons concerned with technical and professional matters. Knowledge about such things has become more specialized through the efforts of scientists and creative technological improvisers. In the many fields of knowledge changed as a result, formal training is now essential for entry into the occupations and for success in a career.[3] The occupations and professions demand that those who fill these positions conform to currently accepted standards of competency. The ideal pattern of knowledge and technique is change, not tradition.

Greater numbers of professionals, more widely dispersed

[2] Eugene V. Schneider, "Types of Productive Systems," in *Industrial Sociology* (New York: McGraw-Hill Book Company, 1957), pp. 29–49.

[3] Edward Gross, "The Career," in *Work and Society* (New York: Thomas Y. Crowell Company, 1958), pp. 143–221; and Theodore Caplow, "Occupational Institutions," in *The Sociology of Work* (Minneapolis: University of Minnesota Press, 1954), pp. 100–123.

than formerly and located more extensively now in varied work settings than in the past, do create problems of communication between professionals with distinct skills. But these difficulties are but part of the problem.

CHANGE AND OCCUPATIONAL PATTERNS

We may expect an ever increasing number of personal problems and an ever pressing necessity for developing improved methods of coping with them. Current knowledge in the professions is in principle always obsolete in the future. For the practitioner already trained, these changes may create strain and stress. Competency in methods accepted earlier as professionally desirable may date an individual among colleagues who are more recently trained. Other problems result from the way in which changes in practices are introduced and evaluated. Some practitioners develop and introduce new methods; others discuss them, try them, and may rework them; other professionals may feel the changes are not acceptable. The suggested innovations may be viewed as not compatible with methods previously mastered and, perhaps by some, as bordering upon ethical limits for professional practice. In several ways, therefore, the behaviors required may disturb deep-seated self-conceptions acquired during systematic professional training and experience.[4]

CLIENT EXPECTATIONS OF PROFESSIONALS

The pattern of activities pursued by public health nurses is not, however, determined exclusively by their own self-conceptions. Like many professions, public health nursing

[4] Robert W. Habenstein and Edwin A. Christ, *Professionalizer, Traditionalizer, and Utilizer* (Columbia, Mo.: University of Missouri Press, 1955), pp. 72–81 and *passim;* and Harvey L. Smith, "Contingencies of Professional Differentiation," *The American Journal of Sociology,* LXIII (January, 1958), 410–14.

seeks to establish itself firmly in the general community and to become recognized as a legitimate group. Outsiders to public health nursing may look upon it with different expectations than those shared by the nurses themselves. For example, when an individual relationship with a patient or his family develops, the latter may view the source of help not as a "nurse," not as a "professional," but rather as a "person." This temptation to respond to the nurse as a person instead of as a professional may create stress in the professional's self-image.[5]

Here is one of the major problems connected with the work of professionals. Under what circumstances does the professional shift ground and carry out one professional service rather than others in order to maintain the relationship with the patient? Such decisions confront these public health nurses and all professionals. But the rational principles upon which decisions like this are made must be difficult to formulate. Many considerations complicate the matter; principles that describe how such decisions should best be made cannot readily be outlined.

ELEMENTS OF PROFESSIONALS' WORK

What work is performed by the public health nurses or by any other professionals? The traditional answer is that professionals provide services which help others resolve problems and satisfy needs of a personal nature. Several other features are ordinarily added. One is that these services cannot be performed by the individual who receives them. Another is that the person who receives these services remains ignorant of the quality of the services provided to him. This means only that he cannot himself effectively

[5] Talcott Parsons, "The Professions and Social Structure," *Social Forces,* XVII (May, 1939), 457–67.

judge what it is that he is getting. He must, so to speak, take it on faith. The product of a professional's work is not a visible object with an easily evaluated price tag attached. At one and the same time, the professional must perform his work, explain or justify it, and in some form or another instill or maintain enough confidence in his patient or client so that the relationship can continue. How far can and should a professional go in these last two phases of his activity in order that the first phase may go on? The client's beliefs and the extent of emotional reassurance that occurs may extend only so far. Society may authorize the professional to carry out functions beyond those which the client or patient may readily accept. Some compromise, perhaps an unsatisfactory one, may result.[6]

In a real sense, professionals acquire from society the freedom, or license, to know unpleasant or dangerous things about people; thus, a certain amount of objectivity and detachment is essential. Indeed, some patients may look for that rather than for emotional support. Here too choices are required, and easily formulated guides to professional behavior are not easy to come by.[7]

PROFESSIONAL TEAMS AND PROFESSIONALS

Another dilemma concerns the consequences for individual profession and individual professional of the growing acceptance of the "team approach." Workers from various disciplines and professions pool their efforts and jointly

[6] T. H. Marshall, "The Recent History of Professionalism in Relation to Social Structure and Social Policy," *Canadian Journal of Economic and Political Science,* V (August, 1939), pp. 325–40; reprinted in his *Citizenship and Social Class and Other Essays* (Cambridge, England: University Press, 1950), pp. 128–55.

[7] Everett C. Hughes, "Licence and Mandate," in *Men and Their Work* (Glencoe, Ill.: The Free Press, 1958), pp. 78–87.

seek a resolution of the patient's difficulties. Many health institutions have come to approve this as a model in establishing new programs and in revising old ones.

However, single solutions to problems may be an illusion. It may not be the case that a team-discussed solution, possibly a compromise, can resolve each set of difficulties. There may be many solutions. The team approach, while attractive and widely renowned at the present time, is not by any means the key to success. Thus, the suggestion of one representative from a single profession, may be more helpful for the patient or for society generally than the compromise worked out by representatives of many professions.

Underlying the work of persons in each profession is a body of fundamental theoretical knowledge. Such is the traditional view. With the rapid multiplication of professions, it is sometimes difficult for them to remain in touch with an underlying body of knowledge or to maintain an identity separate from others. Here is a dilemma of the professions. Regardless of what one calls oneself, and regardless of how one was trained, what does each professional "do"? One answer is to be a member of the team. Such persons might preferably be called "health professionals" or perhaps "personal-problem professionals." Whether independent training and recruitment institutions should be maintained in such a situation is of course somewhat problematic.

Some independence in functions must, it would seem, be preserved. Many professions, of course, assert in vigorous terms their own indispensability and the need for them to remain independent. At most, they nominate themselves as captains of the team. The others who join the team do so as members of the crew responsible to the captain; the price they pay is some loss of independence in work functions.

In one sense, the team approach may create profound problems which cannot readily be resolved. The development of a team may virtually imply the acceptance of an assembly-line division of labor, existing on a single level of technology, with extreme interdependence of professional specialties.

Professions may actually compete in the assumptions that underlie the work performed. The complex division of labor of a team may in fact mean something other than coöperative interdependence.[8] Specialization may require exclusiveness, in which the role of persons from other professions does not receive full sanction. An illustration drawn from a totally different context and indeed, from a culture somewhat different from that in the United States, may be an appropriate example of these points. In Great Britain, municipal governments occasionally establish departments which construct the cities' buildings without resort to private contractors. Who should head these departments? An architect? Or an engineer? According to Hilton's recent review,

> Many borough architects resent the engineer being placed in charge of building because, they say, his civil-engineering training does not give him the detailed building knowledge that the director of a building should possess. On the other hand, they claim that architectural training is directly connected with building, and the architect, therefore, is the person who should logically be given control
>
> A different point of view was taken by one of the building managers: "Under no circumstances should the architect be placed in charge of the construction of buildings," he maintained.[9]

[8] Alvin Zander, Arthur R. Cohen, and Ezra Stotland, *Role Relations in the Mental Health Profession,* Institute for Social Research, University of Michigan (Ann Arbor, 1957), pp. 114–24.

[9] W. S. Hilton, *Building by Direct Labour* (London: The Amalgamated Union of Building Trade Workers, 1954), pp. 32, 49–59.

Some disagreements of this kind seem fundamental to professionals' work because of the nature of their training.

LEARNING IN THE PROFESSIONS

The training received by any professional person by definition is not limited to techniques. The training includes new ways of defining, describing, and thinking about events. The training programs of each profession furnish its new members with unique definitions, descriptive terms, and manners of thought. This learning occurs in all occupations and professions; the learning processes are very general.

Some occupations and professions do, of course, require more learning and more of a fundamental change in outlook and previous modes of thought by trainees than do others. It seems likely, for example, that the greater the degree of specialization in the work of the practitioners, the greater the amount of change required. Some specialties devote a great deal of thought and energy to the formation of training processes which they deem desirable. Nursing may be a current example. On the other hand, training processes may grow in other fields as a result of simple historical imperatives.

Interesting sociological questions can be asked about these training processes, the circumstances of their development, and the degree to which they modify the behavior of those who submit to them. As mentioned above, some training processes are consciously established; others develop through usage and tradition, and under the impact of many different agencies. An example of the former is the change-over in medical-school organization which occurred in the early part of this century. Law-school training, on the other hand, seems more rooted in the past. In many work fields outside the professions, there are notable examples of highly formal training processes, such as in linotype operation, plumbing, and other crafts.

The variable success of training in different fields is noteworthy. In some specialties, retraining for those who have already completed their formal education is sometimes demanded by employing organizations. Engineers, for example, frequently undergo inservice training during the early period of their first postcollege job. Sometimes employing organizations such as hospitals have much influence in the patterning of work demands. Then prior training programs, perhaps controlled by the associations of work specialists, seem to be less widely accepted or tolerated.

In all instances, however, training requirements do equip the student professional with a new set of perspectives which he is to learn in order to behave appropriately in his new roles. Some persons respond to them with ease and confidence. Others may experience trauma. Whether it is the learning of skills for an occupational role or for another role—perhaps as a member of a juvenile gang—new perspectives and modes of thought are acquired during the process. The patterns may be different but the learning processes are similar. Individuals have to learn how to act in manners appropriate to new occupational roles, no matter what the specialty. This is so whether they become janitors or jazz musicians, nurses or physicians, lawyers or accountants, juke-box repairmen or cash girls in department stores.[10] While one goes to medical school for his training, another engages in inservice training as a public health nurse. Still others such as cashiers in department stores, may attend school for two days to learn how to

[10] H. S. Becker, "The Professional Dance Musician and His Audience," *The American Journal of Sociology,* LVII (September, 1951), 136–44; Ray Gold, "Janitors Versus Tenants: A Status-Income Dilemma," *The American Journal of Sociology,* LVII (March, 1952), 486–93; and Dan C. Lortie, "Laymen to Lawmen: Law School, Career-Chance and the Professional Self," *Harvard Educational Review,* XXIX (Fall, 1959), 352–69.

ring registers, deal with customers, fill out sales slips, and the like.

Much of this learning is in formal setting; other learning results from informal experience after formal training is complete. The learning may be formalized in situations specified by a union or professional association or at other times by the employer. What is learned early may contradict the realities of later work experience. Work obligations may violate the ideal professional norms publicly emphasized by employer or by specialty group.

Some fundamental problems faced by the professions and by professionals can be illustrated by the following questions about the effect of the learning process on the self-concepts of the people in the professions.

1 How do individuals come to such learning and rethinking? Some do so readily, others reluctantly. Why this variation?
2 How can professionals best acquire the work orientations which imply a new way of looking at themselves, that is, new self-concepts? What facilitates or retards such learning?
3 When differences occur in the ways in which such new self-concepts are assumed, what are the effects upon abilities of persons to carry out their subsequent job responsibilities and obligations? In other words, how is later role performance affected?
4 How does the acquisition of these varied self-concepts and orientations toward oneself and one's job modify the later course of a person's career in his particular specialty and in the organizations which may employ him?
5 How does this learning and the type of commitment to work, to profession, and to employer thus acquired mod-

ify the nonwork world of the professional? How are family life, recreational activities, and interest in community affairs changed?

Much training for the professions is of course difficult and esoteric. Learning the way to handle emotional aspects of the public health nurse's work may seem very easy; in fact the things which have to be learned may be quite subtle and difficult to grasp in depth and with commitment.

A great deal of the learning of orientations toward roles is affected by nonformal social relationships, most of which are probably unplanned and when not *sub rosa* are at least unofficial. Paradoxically, this kind of learning is of critical significance. University graduate students undoubtedly share a subculture distinct in many ways from the beliefs and perspectives jointly accepted by them and their faculty. Similar ties undoubtedly draw together persons moving into professional roles: The ties may join the students of the same year class, or those who previously prepared at a particular school, or those with prior friendships or loyalties to the home town, or with similar social class or religious interests, or conceivably those with similar plans concerning future specialization. An interesting illustration of the development of a student subculture and its effect on role performance comes from H. S. Becker's study of medical students.[11] Many of them, he reports, cut corners in their laboratory work and pool their findings so as to get the work done and satisfy the faculty's assignments. They develop norms regarding their work and its completion which differ from those of the faculty. They point toward examinations and devalue learning per se, in the interest of completing medical school more easily. Students who for any

[11] H. S. Becker and Blanche Geer, "Student Culture in Medical School," *Harvard Educational Review,* XXVIII (Winter, 1958), 70–80.

reason are isolated from this subculture may encounter greater difficulties. Later on in their careers, the medical professionals may change their outlook toward work. But in order to keep up to date despite a burdensome practice, many still cut corners by relying upon information from friendly detail men or drug salesmen.

Specialization and its demands may affect people in varied ways. Learning how to act professionally may take place more easily for some than for others. Urban persons are familiar with bureaucracies and unions; they are used to working under supervision and are experienced in the ways of getting along with many different people. As Bruce Bliven recently suggested, urban people may be more adaptable to changes in outlook than rural emigrees to the city.[12] Rural youth may have to unlearn many kinds of knowledge and attitudes which are useful in the country and in agricultural occupations but which create unusual and striking difficulties in the vigorously paced and demanding industries and specialties of the city. Those whose parents or siblings have previously passed along accounts of the routines and pressures of work, or who have a family member in some profession, may have an advantage once they are in a professional school by virtue of their acquired, if secondhand, familiarity with the meaning of specialization.

ORIENTATIONS TO WORK DEMANDS

How is performance affected by these diverse orientations to roles? Consider a furrier.[13] If he is skill-oriented, he may be a poor businessman; if status-oriented, he may please customers to the extent of being forced to hire an-

[12] Bruce Bliven, "The City Boy versus the Country Boy," *The New York Times Magazine,* August 16, 1959, pp. 20, 26, 28.

[13] Louis Kriesberg, "The Retail Furrier: Concepts of Security and Success," *The American Journal of Sociology,* LVII (March, 1952), 478–85.

other furrier or an assistant to help out with work behind the scene. Also, consider the orientations of intellectuals employed by labor unions.[14] They may see themselves as professionals who happen to be employed by a union, or as missionaries who seek to lift the vision of workers. Such alternative orientations undoubtedly affect how men work, the personal rewards they obtain from their work, how they involve themselves with others, their sources of satisfactions, and their responses to the challenges placed before them by superiors. In time, when different specialties work together, the specialist's own view of himself comes to be known to other people with whom he works. Within the union, for example, the missionary, dedicated to political reform, may come to be viewed as a rather excitable person, and as humorless, but of great value during the crisis of an organizing effort or an internal upheaval. The union president, who rose with effort through the organization's ranks, may turn to other specialists for a statistical study of trends in the industry.

These orientations can be classified in many ways. One is along the range from "highly professional" to "highly organizational," depending upon whether the person's main commitment is to his work colleagues, regardless of the location of their employment, or to the current organization in which he may hope to develop his career. Another is to view these orientations as either "local," that is mainly attached to the employing organization, or as "cosmopolitan," attached to professional colleagues.[15] The latter per-

[14] Harold L. Wilensky, *Intellectuals in Labor Unions: Organizational Pressures on Professional Roles* (Glencoe, Ill.: The Free Press, 1956), pp. 111–74; Joel Seidman *et al., The Worker Views His Union* (Chicago: University of Chicago Press, 1958), pp. 241–54.

[15] Alvin W. Gouldner, "Cosmopolitans and Locals: Toward an Analysis of Latent Social Roles—I and II," *Administrative Science Quarterly,* II (December, 1957), 281–306; and II (March, 1958), 444–80; and

son may resist the more blatant coercions and appeals of immediate supervisors; the former may ultimately become the old guard in the organization.

ORGANIZATIONAL CAREERS AND PROFESSIONAL CAREERS

In professional fields of work generally, this distinction between the profession itself and the organization is a basic one. Many organizations attempt to train professionals to do things "our way." In time, this may wither the capabilities of professionals so extensively that their career mobility and marketability outside the organization are reduced. This is a basic dilemma for all professionals and indeed for all specialists. All organizations create demands and place pressures on specialists which affect role performance; the actor responds to these demands on the basis of his view of the role.

In some professional fields, the skills and attitudes taught to prospective practitioners may reflect practices that are out-of-step with current demands that are accepted by full-fledged practitioners. They may be outmoded, yet supported by the institutionalized traditions of the schools, or they may be advanced beyond the current competence of professionals or of employing organizations. Scientific developments may rapidly be incorporated into the educational experiences of new practitioners. Previously trained practitioners, and approved practices in tradition-oriented institutions, may lag behind.[16]

Promotions and advancements within one's profession and within the organization where one works may not de-

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Donald R. Cressey, "Professional Correctional Work and Professional Work in Correction," *National Probation and Parole Association Journal,* V (January, 1959), 1–15.

[16] Robert K. Merton, "The Functions of the Professional Association," *The American Journal of Nursing,* LVIII (January, 1958), 50–54.

pend on the same factors. They clearly are affected by the orientations which individuals display toward their work roles and how these are viewed by others. It is often said that the man who is on the way up in an organization is disliked by his peers. One reason for this is that he may be on an escalator for advancement while they are not.[17] In time, he may have to supervise and discipline his former peers. In other instances, mobility and promotions may be impeded by loyalty to peers; the man who likes his co-workers may not be sufficiently motivated or ambitious to move ahead; the people above him who decide on promotions may come not to view him as supervisory or administrative material.

An intriguing case in point is that of artists.[18] A painter may view himself as a fine artist, who prefers expressionism, abstractionism, or impressionism as styles for his creative product. When he paints in this fashion, he may find it difficult to sustain himself financially, especially if his style is not popular. His own work standards may be high as he views them, but they may not be acceptable to the public. He may, therefore, become a commercial artist or teach art, and continue to paint as he wishes on a part-time basis. With some difficulty he may try to incorporate the standards of his valued self-image as a painter into his illustrating or teaching. At another extreme, the artist may refuse to consider what he calls compromises and may either starve or enter another field of work entirely.

Many professionals maintain their work self-concepts at great sacrifice, even long after counterpressures make regu-

[17] Norman H. Martin and Anselm L. Strauss, "Patterns of Mobility within Industrial Organizations," *Journal of Business,* XXIX (April, 1956), 101–10; and H. S. Becker and Anselm L. Strauss, "Careers, Personality, and Adult Socialization," *The American Journal of Sociology,* LXII (November, 1956), 253–63.

[18] Mason Griff, "The Recruitment of the Artist," unpublished paper.

lar re-enforcement impossible. A fascinating illustration is the experience of professionals during the depression, many of whom were unemployed for many years during the 1930's. Refugee intellectuals who fled Germany during the Hitler period are another example. Torn from their universities and handicapped by language barriers as well as by age and religious prejudice, many found it difficult to maintain their work identity. The establishment of the New York School for Social Research in New York, largely by refugee scholars during the 1930's, illustrates the steps that professionals took to provide or reprovide a work and organizational setting which re-enforced and rewarded their views of themselves.

TECHNIQUE CHANGES, SPECIALTY CAREERS, AND ROLES

Life careers are often affected by changes in techniques connected with professional obligations. Procedures previously mastered may become outmoded, while new methods prove too difficult for easy learning. Keeping up-to-date may be idealized by professional leaders, employers, and co-workers. Tensions and strains may thereby arise, as new obligations confront ingrained self-concepts. Not all professionals resolve these in manners approved by their professions, but many take some steps in that direction. The professional may take refresher courses or inservice training courses; the sociologist studies statistics books and learns about computers; the automobile-repair shop manager sends his newest garage mechanic to a week of school to learn about removable car radios and the repair of power brakes and windows; the optometrist attends a course on contact-lens fitting at an associational conference.[19]

[19] Louis H. Orzack and John R. Uglum, "Sociological Perspectives of the Profession of Optometry," Monograph 230, *American Journal of Optometry,* Archives of American Academy of Optometry.

Distress may accompany these technological displacements, especially perhaps if the professional-specialist believes that a member of another specialty is taking control of the new work. Thus, recently, a conflict between airline pilots and flight engineers, concerning the proper role of each at the business end of the airplane, led to a strike. Resistance to changeovers in work responsibilities often occurs. Tension may persist until it is clearly accepted that the new allocation of responsibility can be properly handled by a different specialty. The new allocation may not be viewed as morally acceptable. Resistance to displacement of work functions by others or by new machines often occurs. Typographers feel their role is threatened by the potential loss of job control when publishers import advertising matrices set in outside shops. Musicians are concerned about the impact of new technological devices for the reproduction of music. Painters are distressed by the development of spray equipment. Plumbers fear the adoption of plastic pipe. Social workers ponder and are uncertain about the roles of lawyers and physicians in the processing of adoptions.

SELF, WORK, AND ROLE

The profoundly personal involvement of man with his work has been underscored throughout all of the foregoing. For most professionals, work and its responsibilities seem to be truly central to their interests.[20] Yet, in our modern society, far-reaching changes affect the meanings connected with work, no less for professionals than for industrial workers. The ferocious drive and endless toil, derivative from the Protestant ethic and emphasized during expansive urban and industrial growth, have been minimized. Or-

[20] Louis H. Orzack, "Work as a 'Central Life Interest' of Professionals," *Social Problems,* VII (Fall, 1959), 125–32, *Reprint Series* No. 8, The University of Wisconsin Industrial Research Center, Madison, Wis.

ganizationally situated careers pattern the motivations of professionals as well as of industrial workers. Hours of work have declined rapidly for industrial workers, less so for professionals.[21] Administrative, supervisory, and professional (or quasi-professional) components of the labor force have expanded proportionately as front-line production jobs have dwindled.

These social changes have increased the responsibilities that confront professionals. Indeed, it is change itself that provides challenges aimed particularly at professionals. The professions rest essentially upon a foundation of abstract knowledge, scientifically established. That base changes incessantly; it is not static. In principle, therefore, professionals must tolerate and welcome change in their activities, as new problems arise and new methods for providing services to others develop. The underlying component of professional relationships is not, therefore, patterned techniques which become outmoded after every generation. The professional is intensely involved in the performance of his work, and in his efforts to understand and to help resolve the pressing, emotion-tinged, and ever changing problems of those who come to him.

His success is satisfying to those he serves, vital to society generally, and profoundly rewarding to himself as a person.

SOME QUESTIONS FOR DISCUSSION

1 How do professions respond to change?
2 Why do some professionals welcome change in their activities and others resist it?
3 How are professionals in a particular field affected by the rise of other professions?

[21] Louis H. Orzack and Eugene A. Friedmann, "Work and Leisure Interrelationships," Fourth World Congress of Sociology (Milan, Italy, September, 1959), section on "Leisure." (Publication in process.)

4 What is the desirable balance between emotional concern for clients and objectivity in meeting the needs of clients?
5 How can representatives of different specialties work best together?
6 What can professionals in a team do to contribute most effectively to client needs?
7 Does the team approach weaken or strengthen professional contributions to the solution of personal problems of clients?
8 How can new techniques best be transmitted to professionals who are already in practice?
9 How is the process of professional learning hindered or helped by attitudes which students bring with them from earlier experiences?
10 What are the most adequate methods for modifying attitudes that students bring to their training?

Books for Reference

NOTE.—These books are primarily meant for use by instructors. They deal with the following topics: (1) personality, (2) teaching-learning process, (3) psychological aspects of nursing, (4) motivation and dynamics of behavior, (5) mental health in public health, (6) child development, (7) common patterns of neurotic behavior in children and adults, (8) emotional and social factors in illness and handicaps, (9) principles and methods of health education, (10) cultural aspects of health, illness, and medical care.

Alexander, Franz. *Psychosomatic Medicine: Its Principles and Applications.* New York: W. W. Norton & Company, Inc., 1950.

Barker, Roger, *et al. Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability,* rev. ed. (Social Science Research Council, Bulletin 55.) New York, 1953.

Baruch, Dorothy. *New Ways in Discipline.* New York: Whittlesey House, 1949.

Bellack, Leopold. *Psychology of Physical Illness.* New York: Grune and Stratton, 1952.

Blake, Florence. *The Child, His Parents, and the Nurse.* Philadelphia: J. P. Lippincott Company, 1954.

Bowlby, John. *Maternal Care and Mental Health.* Geneva: World Health Organization, 1951.

Burton, Genevieve. *Personal, Impersonal, and Interpersonal Rela-*

tions: A Guide for Nurses. New York: Springer Publishing Co., Inc., 1958.

Cameron, Norman, and Ann Magaret. *Behavior Pathology.* Boston: Houghton Mifflin Company, 1951.

Cantor, Nathaniel. *Dynamics of Learning.* Buffalo: Foster and Stewart, 1946.

———. *Learning through Discussion.* Buffalo: Human Relations for Industry, 1951.

———. *The Teaching-Learning Process.* New York: Dryden Press, 1953.

Church, Joseph, and L. Joseph Stone. *Childhood and Adolescence: A Psychology of the Growing Person.* New York: Random House, Inc., 1957.

Dysinger, Robert. *Mental Health in the United States.* Annals of the American Academy of Political and Social Science, 1953.

English, O. Spurgeon, and Gerald Pearson. *Common Neuroses of Children and Adults.* New York: W. W. Norton & Company, Inc., 1937.

Erikson, Erik. *Childhood and Society.* New York: W. W. Norton & Company, Inc., 1950.

Field, Minna. *Patients Are People.* New York: Columbia University Press, 1953.

Freud, Anna. *Ego and the Mechanisms of Defense.* New York: International Universities Press, Inc., 1957.

Freud, Sigmund. *Civilization and Its Discontents.* London: Hogarth Press, 1957.

Galdston, Iago (ed.). *Motivation in Health Education.* (Academy of Medicine Annual Health Education Conference.) New York: Columbia University Press, 1948.

Garrett, Annette. *Interviewing: Its Principles and Methods.* New York: Family Service Association of America, 1958.

Gilbert, Ruth. *The Public Health Nurse and Her Patient,* 2nd ed. Cambridge: Harvard University Press for the Commonwealth Fund, 1951.

Ginsburg, Ethel. *Public Health Is People.* New York: Commonwealth Fund, 1950.

Ginzberg, Eli (ed.). *The Nation's Children.* 3 vols. (Prepared for the Golden Anniversary Whitehouse Conference on Children and Youth.) New York: Columbia University Press, 1960.

Greenberg, Harold, *et al. Child Psychiatry in the Community.* New York: G. P. Putnam's Sons, 1950.

Grinker, Roy, and Fred Robbins. *Psychosomatic Casebook.* Philadelphia: Blakiston Company, 1954.

Hilgard, Ernest R. *Theories of Learning.* New York: Appleton-Century-Crofts, Inc., 1956.

Hoch, Paul, and Joseph Zubin. *Anxiety.* New York: Grune and Stratton, 1950.

Horney, Karen. *Neurosis and Human Growth: The Struggle toward Self-Realization.* New York: W. W. Norton & Company, Inc., 1950.

Hunt, J. McV. (ed.). *Personality and the Behavior Disorders.* New York: Ronald Press Co., 1944.

Jahoda, Marie. *Current Concepts of Positive Mental Health.* New York: Basic Books, Inc., 1958.

Jersild, Arthur T. *In Search of Self.* New York: Teachers College, Columbia University, 1952.

———. *Psychology of Adolescence.* New York: Macmillan Company, 1957.

———. *When Teachers Face Themselves.* New York: Teachers College, Columbia University, 1955.

Josselyn, Irene. *The Happy Child.* New York: Random House, Inc., 1955.

———. *Psychosocial Development of Children.* New York: Family Service Association of America, 1948.

Kahn, Robert, and Charles Cannell. *The Dynamics of Interviewing.* Philadelphia: John Wiley & Sons, Inc., 1957.

Kanner, Leo. *Child Psychiatry,* rev. ed. Springfield, Ill.: Charles C. Thomas, 1948.

Kelley, Earl C. *Education for What Is Real.* New York: Harper and Brothers, 1947.

Kelley, Earl C., and Marie Rasey. *Education and the Nature of Man.* New York: Harper and Brothers, 1957.

Klein, Henriette, *et al. Anxiety in Pregnancy and Childbirth.* New York: Paul Hoeber, Inc., Medical Book Dept. of Harper and Brothers, 1950.

Kotinsky, Ruth, and Helen L. Witmer. *Community Programs for Mental Health.* Cambridge: Harvard University Press, 1955.

Krugman, Morris. *Orthopsychiatry and the School.* American Orthopsychiatric Association, 1958.

Lemkau, Paul V. *Mental Hygiene in Public Health,* rev. ed. New York: McGraw-Hill Book Company, Inc., 1955.

Levy, D., and L. Monroe. *The Happy Family.* New York: Alfred A. Knopf, Inc., 1940.

Lippman, Hyman S. *Treatment of the Child in Emotional Conflict.* New York: McGraw-Hill Book Company, Inc., 1956.

May, Rollo. *The Meaning of Anxiety.* New York: Ronald Press Co., 1950.

Montagu, Ashley. *Education and Human Relations.* New York: Grove Press, Inc., 1958.

Mowrer, O. H. *Learning Theory and Personality Dynamics.* New York: Ronald Press Co., 1950.

Murphy, Gardner. *Human Potentialities.* New York: Basic Books, Inc., 1958.

Muse, Maude. *Guiding Learning Experience: Principles of Progressive Education Applied to Nursing Education.* New York: Macmillan Company, 1950.

Paul, Benjamin. *Health, Culture, and Community.* New York: Russell Sage Foundation, 1955.

Peplau, Hildegarde. *Interpersonal Relations in Nursing.* New York: G. P. Putnam's Sons, 1952.

Plant, James S. *Personality and the Cultural Pattern.* New York: Commonwealth Fund, 1937.

Reymert, Martin. *Feelings and Emotions.* New York: McGraw-Hill Book Company, Inc., 1950.

Richardson, Henry. *Patients Have Families.* New York: Commonwealth Fund, 1945.

Robinson, G. C. *The Patient as a Person: A Study of the Social Aspects of Illness.* New York: Commonwealth Fund, 1949.

Roe, Anne. *The Psychology of Occupations.* New York: John Wiley & Sons, Inc., 1956.

Rogers, C. R. *Client-centered Therapy.* Boston: Houghton Mifflin Company, 1951.

Saul, Leon. *Emotional Maturity.* Philadelphia: J. P. Lippincott Company, 1947.

Seidenfeld, Morton A. *Psychological Aspects of Medical Care.* Springfield, Ill.: Charles C. Thomas, 1949.

Selye, Hans. *The Stress of Life.* New York: McGraw-Hill Book Company, Inc., 1956.

Simmons, Leo, and Harold G. Wolff. *Social Science in Medicine.* New York: Russell Sage Foundation, 1954.

Snygg, Donald, and Arthur Combs. *Individual Behavior.* New York: Harper and Brothers, 1949.

Symonds, P. M. *The Dynamics of Human Adjustment.* New York: Appleton-Century-Crofts, Inc., 1946.

———. *Dynamics of Parent-Child Relationships.* New York: Teachers College, Columbia University, 1949.

Towle, Charlotte. *The Learner in Education for the Professions.* Chicago: University of Chicago Press, 1954.

Upham, Frances. *A Dynamic Approach to Illness.* New York: Family Service Association of America, 1949.

Whitehouse Conference on Children and Youth. *A Healthy Personality for Every Child.* Raleigh: Health Publications Institute, Inc., 1951.

Witmer, Helen L. (ed.). *Teaching Psychotherapeutic Medicine.* New York: Commonwealth Fund, 1947.

———. *Pediatrics and the Emotional Needs of the Child.* New York: Commonwealth Fund, 1948.

Workman, Arthur, and Robert Stewart. *Children and Other People: Achieving Maturity through Learning.* New York: Dryden Press, 1957.

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